1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 181 89 23421

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM FREDERICK ADAMS				2. DATE OF DEATH (Month, Day, Year): AUGUST 25, 1989	3. TIME OF DEATH: 4:55 P. M
4. SOCIAL SECURITY NUMBER: 223 22 9080	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-3-24	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): VA MEDICAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: FORT HOWARD, MD		9c. COUNTY OF DEATH: BALTIMORE COUNTY
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 527 N. POTOMAC STREET		10f. ZIP CODE: 21205			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician		16b. KIND OF BUSINESS/INDUSTRY: Electrical	
17. FATHER'S NAME (First, Middle, Last): FREDERICK ADAMS		18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE RAINES			
19a. INFORMANT'S NAME (Type/Print): CLINICAL RECORDS, VAMC		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): VA FORT HOWARD, MD 21052			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): VA		20c. LOCATION — City or Town, State: Crownville, Md Vets	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roland P. Hartley Jr		22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley F,H. Inc 2135 Dundalk Ave Balto, MD 2122 Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	2 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. RESPIRATORY FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ATHEROSCLEROTIC HEART DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
		▶ 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.V.J. VERGHESE, M.D. VA MEDICAL CENTER FORT HOWARD, MD 21052

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23422

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cornelius L. Bents			2. DATE OF DEATH (Month, Day, Year): 8 28 89	3. TIME OF DEATH: 5:08 PM
4. SOCIAL SECURITY NUMBER: 213-01-2349	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-06-13	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: ======

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 336 West Arden Road		10f. ZIP CODE: 21225	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Branch Manager	16b. KIND OF BUSINESS/INDUSTRY: Equitable Trust	
17. FATHER'S NAME (First, Middle, Last): Lambert W. Bents		18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Connors	
19a. INFORMANT'S NAME (Type/Print): Helen Bents		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 336 West Arden Road Baltimore, Maryland 21225	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery	20c. LOCATION — City or Town, State: Brooklyn Park, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Franciewski		22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Laurence P. Sherman MD	29c. LICENSE NUMBER: D37200	29d. DATE SIGNED (Month, Day, Year) ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lawrence D. Sherman, M.D. Harbor Hospital E.D.		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Jake Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23423

9

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Wesley Bell NMI				2. DATE OF DEATH: MONTH 08 DAY 27 YEAR 89	3. TIME OF DEATH: 3:45 PM
4. SOCIAL SECURITY NUMBER: 266-18-9947	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10/16/15	8. BIRTHPLACE (State or Foreign Country): SC
9a. FACILITY NAME (If not institution, give street and number): University of Maryland			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Maryland		9c. COUNTY OF DEATH: Baltimore City
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Baltimore City	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1424 Riggs Ave		10f. ZIP CODE: 21217			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Longshoreman		16b. KIND OF BUSINESS/INDUSTRY: Steamship Trade	
17. FATHER'S NAME (First, Middle, Last): John Wesley Bell			18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Thomas		
19a. INFORMANT'S NAME (Type/Print): Pernella Lewis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 258 Mt Hope Pl / Bronx, NY 10457			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet Cem		20c. LOCATION — City or Town, State: Owings Mills, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Williams		22. NAME AND ADDRESS OF FACILITY: WM. C. March F/H 1101 E. North Ave			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia	10 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Multi infarct Dementia	3 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension Right Lung Mass
Renal insufficiency Peripheral Vascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
B. Wayne Reese M.D.	D37410	▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Benjamin Wayne Reese M.D. 120 S. Green Street Family Medicine

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23424

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN LAWRENCE BEST				2. DATE OF DEATH (Month, Day, Year): AUGUST 24, 1989	3. TIME OF DEATH: 2:10 P M
4. SOCIAL SECURITY NUMBER: 213-01-6816	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): AUGUST 12, 1909	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): WILSON HEALTH CARE			9b. CITY, TOWN OR LOCATION OF DEATH: GAITHERSBURG		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: GAITHERSBURG	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 403 RUSSELL AVENUE		10f. ZIP CODE: 20877	10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPPLY OFFICER	16b. KIND OF BUSINESS/INDUSTRY: MONT. COUNTY POLICE	
17. FATHER'S NAME (First, Middle, Last): MARTIN R. BEST		18. MOTHER'S NAME (First, Middle, Maiden Surname): NETTIE CASHELL	
19a. INFORMANT'S NAME (Type/Print): ELIZABETH DUNLEVY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4701 WILLARD AVE. CHEVY CHASE, MD. 20815	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY	20c. LOCATION — City or Town, State: BRENTWOOD, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Muriel H. Barber		22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adeno-carcinoma, Gall Bladder	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus
A.S.H.D.
Residuae of C.V.A

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jack Schumacher M.D.	29c. LICENSE NUMBER: DO 9923	29d. DATE SIGNED (Month, Day, Year): ▶ 8-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Jack Schumacher Gaithersburg, Md. 20877		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23425
REG. NO.

2

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSE BLOOM			2. DATE OF DEATH (Month, Day, Year): 8-26-89	3. TIME OF DEATH: 6:15 PM
4. SOCIAL SECURITY NUMBER: 234 58 1812	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 16, 1894	8. BIRTHPLACE (State or Foreign Country): Hungary
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Greater Washington		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2105 Reedie Drive	10f. ZIP CODE: 20902	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Max Marowitz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Farkas	
19a. INFORMANT'S NAME (Type/Print): Larelda Gruber		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same address as #10	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beth Jacob Cemetery	20c. LOCATION — City or Town, State: Charleston, WV
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes, Falls Church, Va. 22046	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ARTERIOSCLEROTIC HEART DISEASE.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. CARDIAC ARRYTHMIAS	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: P. Talwar, MD.	29c. LICENSE NUMBER: D 36552	29d. DATE SIGNED (Month, Day, Year): ▶ 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Pankaj Talwar. Hebrew Home of Greater Washington. Rockville Md 20852.		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kinard	

DHMH-16 Rev 1/89

89 23426

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Percy / BLACK			2. DATE OF DEATH (Month, Day, Year): 8-24-89	3. TIME OF DEATH: 10:30 PM
4. SOCIAL SECURITY NUMBER: 579-03-4677	5. SEX: 1 M 2 F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-1-04	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): LEVINDALE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: 2434 W. BELEDERE 21205		9c. COUNTY OF DEATH: BALTO

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER: 1309 DALLAS		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (LABOR)	16b. KIND OF BUSINESS/INDUSTRY: COOK	
17. FATHER'S NAME (First, Middle, Last): CALVIN BLACK		18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTA ROSS	
19a. INFORMANT'S NAME (Type/Print): LAURA BLACK	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 N. DALLS ST. BALTO. MD 21213		
20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTVIEW CEMETERY	20c. LOCATION — City or Town, State: BALTO. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bettis Funeral Home	22. NAME AND ADDRESS OF FACILITY: 1129 N. CAROLINE ST BALTO MD 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	2 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)

27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: STATE MD	29c. LICENSE NUMBER: D30951	29d. DATE SIGNED (Month, Day, Year): 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AJ LUCCO MD 2434 W. BELVEDERE AVE. BALTO 21215-5259

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Burgess

DHMH-16 Rev 1/89

Items:23 thru 28f per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23427

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William J. Butler,II				2. DATE OF DEATH (Month, Day, Year): 8-19-89	3. TIME OF DEATH: 9:30AM M
4. SOCIAL SECURITY NUMBER: 216-82-8220	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 28 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3 4 61	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 309 Lynhurst Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? XX YES 2 ☐ NO
10e. STREET AND NUMBER: 309 LYNHURST ST.		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY? US

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABOR	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): WILLIAM J. BUTLER SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): BERLIN BRAY	
19a. INFORMANT'S NAME (Type/Print): BERLIN BUTLER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 LYNHURST ST. BALTIMORE, MD. 21229	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEM. PK.	20c. LOCATION — City or Town, State: ARBUTUS , MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] #281		22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 N. MONROE STREET 21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute narcotic and alcohol intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 XX Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-19-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): UNKNOWN			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): UNKNOWN

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-19-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23428

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNEST BORITZ

2. DATE OF DEATH (Month, Day, Year): 8 25 89

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 217-44-0106

5. SEX: 1 ☐ M 2 ☐ F — XX

6. AGE (In yrs. last birthday): 91 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8-31-1897

8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville

9b. CITY, TOWN OR LOCATION OF DEATH: Laurel

9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: Howard

10c. CITY, TOWN OR LOCATION: Columbia

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 9470 Guilford Rd.

10f. ZIP CODE: 21046

10g. CITIZEN OF WHAT COUNTRY?: Usa

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4 or 5+): unk

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer

16b. KIND OF BUSINESS/INDUSTRY: own

17. FATHER'S NAME (First, Middle, Last): Andrew Boritz

18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Sara Toole

19a. INFORMANT'S NAME (Type/Print): Mr. Kenneth Boritz

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2901 Illinois Ave, Balt.Md. 21227

20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cem.

20c. LOCATION — City or Town, State: Elkridge

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Dallas Slack Moo535

22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home
PO Box 268 Ellicott City 21043

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. VENTRICULAR ARRHYTHMIA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE CARDIOMYOPATHY
ASPIRATION PNEUMONITIS
DYSPHAGIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D24035

29d. DATE SIGNED (Month, Day, Year): 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FESMALHADD 321 PRINCE GEORGE ST

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23429

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BLANCHE J BARNETT			2. DATE OF DEATH (Month, Day, Year): ~~AUG~~ 25 ~~89~~	3. TIME OF DEATH: 1.15 AM M
4. SOCIAL SECURITY NUMBER: 217 30 4220	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 6, 1935	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8014 Solley Rd.		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Real Estate Agent	16b. KIND OF BUSINESS/INDUSTRY: Real Estate Company	
17. FATHER'S NAME (First, Middle, Last): Norris Matthews		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Reichert	
19a. INFORMANT'S NAME (Type/Print): Rich E. Barnett		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8014 Solley Rd., Glen Burnie, MD 21061	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Steph D Hammond		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ventricular Tachycardia / Fibrillation	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Atherosclerotic Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marc Okun MD	29c. LICENSE NUMBER: D28000	29d. DATE SIGNED (Month, Day, Year): 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARC OKUN, M.D. 615 HAMMONDS LANE BALTIMORE, MARYLAND 21225

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Jane Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6+1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23430

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERNARD HENRY BENTE, SR.					2. DATE OF DEATH (Month, Day, Year): AUGUST 21, 1989	3. TIME OF DEATH: 19.11 M
4. SOCIAL SECURITY NUMBER: 219-10-9054	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): SEPT. 27, 1926	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: ANNE ARUNDEL	
RESIDENCE OF DECEDENT						
10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: PASADENA			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 105 DuPONT AVENUE		10f. ZIP CODE: 21122			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: APR 46 - APR 47	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 5+): none		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UPHOLSTERER			16b. KIND OF BUSINESS/INDUSTRY: FURNITURE	
17. FATHER'S NAME (First, Middle, Last): BERNARD BENTE					18. MOTHER'S NAME (First, Middle, Maiden Surname): LYDIA (LEGG)	
19a. INFORMANT'S NAME (Type/Print): MR. TERRY BENTE					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 MANNING RD., GLEN BURNIE, MD 21061	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD VETERAN'S CEM. CROWNSVILLE			20c. LOCATION — City or Town, State: CROWNSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shane Savage		22. NAME AND ADDRESS OF FACILITY: McCULLY FUNERAL HOME			3204 MOUNTAIN RD PASADENA, MD21122	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIAC ARREST.
DUE TO (OR AS A CONSEQUENCE OF):
b. HTN / DM.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
H R Tamler M.D	D21864	▶ 8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
3234 Mountain Rd PASADENA MD 21122

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23431

26

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWIN DANIEL BELL SR			2. DATE OF DEATH (Month, Day, Year): August 27 89	3. TIME OF DEATH: 0709 AM M
4. SOCIAL SECURITY NUMBER: 215.09.9630	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 20, 1915	8. BIRTHPLACE (State or Foreign Country): Wash. D.C.
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Severn	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7915 Clark Station Road		10f. ZIP CODE: 21144	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): President	16b. KIND OF BUSINESS/INDUSTRY: Bus Company	
17. FATHER'S NAME (First, Middle, Last): John E. Bell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Piller	
19a. INFORMANT'S NAME (Type/Print): John E. Bell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7913 Clark Station Road, Severn, Md. 21144		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Elkridge, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic heart disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive Heart failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ~~Renal insufficiency~~ error J.R.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D36256	29d. DATE SIGNED (Month, Day, Year) ▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. J.M. RAMIREZ, M.D. 7845 OAKWOOD ROAD #205 GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23432
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY CARTER				2. DATE OF DEATH (Month / Day / Year): 08 / 20 / 89	3. TIME OF DEATH: 830A M
4. SOCIAL SECURITY NUMBER: 220-24-9437	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2 4 21	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1005 EDMONDSON AVE.		10f. ZIP CODE: 21223		10g. CITIZEN OF WHAT COUNTRY?: US	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X			14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): FRANCIS CARTER		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY GARNER			
19a. INFORMANT'S NAME (Type/Print): MARSHA MARION		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5207 ST. CHARLES ST. 21215			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEM. PK.		20c. LOCATION — City or Town, State: ARBUTUS MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] #281		22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 N. MONROE STREET 21217			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. R/O ARRHYTHMIAS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. BREAST CANCER with BONE METS

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- HYPOTHYROIDISM
- HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D37233	▶08-20-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH HUBAYKAH . MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23433

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Page 4 must be filed with the local registrar prior to burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
EARL	L.	CANAPP SR.	August 22, 1989	8:35 P. M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-12-5608	1 X M 2 ☐ F	65 YRS.			Sept. 2, 1923	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
408 Dale Avenue	Overlea	Baltimore

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore	Overlea	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
408 Dale Avenue	21206	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ YES 2 ☐ NO — WW II	1 ☐ YES 2 ☑ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Insurance Agent	Insurance

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sherman O. Canapp	Isabelle S. Lavender

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Josephine Canapp	408 Dale Avenue Baltimore, Maryland 21206

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gardens of Faith Cemetery 8/26/89	Baltimore Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Michael Ruck	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple myeloma	17 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Sheldon C. Kravitz, M.D.	D05039	▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Sheldon C. Kravitz, M.D. Union Memorial Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23434

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MADELINE CHANNELL				2. DATE OF DEATH (Month / Day / Year): 8 / 16 / 89	3. TIME OF DEATH: 2:55 am M
4. SOCIAL SECURITY NUMBER: 215 22 9189	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 98 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 11, 1890	6. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Riverview N. Home		9b. CITY, TOWN OR LOCATION OF DEATH: ESSEX		9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE - DUNDALK		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 110 BALTIMORE AVE.		10f. ZIP CODE: 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 YRS; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME	16b. KIND OF BUSINESS/INDUSTRY:			
17. FATHER'S NAME (First, Middle, Last): LAURENCE SEIBERT		18. MOTHER'S NAME (First, Middle, Maiden Surname): BARBARA WILDE			
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY		20c. LOCATION — City or Town, State: BALTO. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul T. Evans, Jr.		22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED: N/A
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
ATTENDING PHYS.	02960	▶ 8/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH B. KLUGMAN, MD / EASTERN BLVD. BALT. MD. 21221

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

Item #6 per FH 8/30/89 sp

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-23435 89-23435

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marian F. Cook

2. DATE OF DEATH: MONTH Aug. DAY 24, YEAR 1989

3. TIME OF DEATH: 8:20 AM

4. SOCIAL SECURITY NUMBER: 214-14-9729

5. SEX: 1 ☐ M 2 ☐ F

6. AGE (In yrs. last birthday): 77 ~~76~~ YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 02/22/12

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 103 Waelchli Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Halethorpe

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Halethorpe

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 103 Waelchli Avenue

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+)

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): elev. oper.

16b. KIND OF BUSINESS/INDUSTRY: gov't.

17. FATHER'S NAME (First, Middle, Last): Francis Donovan

18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy M. Bunch

19a. INFORMANT'S NAME (Type/Print): Mrs. Jean M. Egan

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 505 Sudbury Road Linthicum Md 21040

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park

20c. LOCATION — City or Town, State: Dorsey, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature]

22. NAME AND ADDRESS OF FACILITY: AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD, ARBUTUS, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. (1) EXTENSIVE DEEP VEIN THROMBOPHLEBITIS

DUE TO (OR AS A CONSEQUENCE OF):
b. BILATERAL DVT TO FEMORAL ~~VEIN~~ VEIN WITH PULMONARY EMBOLI

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. (2) SUSPECTED METASTATIC CANCER TO LUNG - PRIMARY

DUE TO (OR AS A CONSEQUENCE OF):
d. NOT DETERMINED

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEIZURES

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Albin O. Kuhn II MD

29c. LICENSE NUMBER: D21336

29d. DATE SIGNED (Month, Day, Year) ▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALBIN KUHN II MD, 1001 PINE HEIGHTS AVE, SUITE 202, BALT, MD 21229

31. DATE FILED (Month, Day, Year): AUG 28 1989

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23436

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Albert Winfield Caples			2. DATE OF DEATH (Month, Day, Year): August 28, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 196.09.1142	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept 19, 1912	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 5900 Upland Road		9b. CITY, TOWN OR LOCATION OF DEATH: Brooklyn Park		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5900 Upland Road		10f. ZIP CODE: 21225	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): NA	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Driving Instructor	16b. KIND OF BUSINESS/INDUSTRY: Maryland D.M.V.	
17. FATHER'S NAME (First, Middle, Last): Winfield S. Caples		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida M. Tate	
19a. INFORMANT'S NAME (Type/Print): Julia E. Caples		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins		22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Ave. S.W., Glen Burnie, Md. 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chronic Obstructive pulmonary disease with	many yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. hypoxemia.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic CVD with congestive heart failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28c. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Morton M. Krieger M.D.	29c. LICENSE NUMBER: D 06675	29d. DATE SIGNED (Month, Day, Year): ▶ Aug 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M.M. KRIEGER M.D. 606 HAMMONDS LANE BALTIMORE, MD. 21225		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Judith Davidson Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23437

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Michael Cushman

2. DATE OF DEATH (Month, Day, Year): 8-28.1989

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 216-44-3414

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 92 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10-2--1896

8. BIRTHPLACE (State or Foreign Country): Conneticut

9a. FACILITY NAME (If not institution, give street and number): 4314 Valley View Ave.

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: --------

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: --------

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 4314 Valley View Ave

10f. ZIP CODE: 21206

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk

16b. KIND OF BUSINESS/INDUSTRY: Post Office

17. FATHER'S NAME (First, Middle, Last): Unknown

18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown

19a. INFORMANT'S NAME (Type/Print): Mrs. Frances B. Cushman

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4314 Valley View Ave. Balto., Md. 21206

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WoodLawn Cemetery

20c. LOCATION — City or Town, State: Balto., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Hartley Miller

22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home
7627 Harford Rd. Balto., Md. 21234

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):
b. UNSTABLE ANGINA

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marcio M. Menendez MD

29c. LICENSE NUMBER: D07697

29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARCIO M. MENENDEZ MD 5820 YORK RD BALTIMORE MD 21212

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsella

DHMH-18 Rev 1/89

Item#11 Film#g655 09/22/89 per F.H. da 2

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23438

3

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician; pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Deckert, George			2. DATE OF DEATH (Month, Day, Year): 8 25 89	3. TIME OF DEATH: 3 30P M
4. SOCIAL SECURITY NUMBER: 215-16-7251	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-22-06
8. BIRTHPLACE (State or Foreign Country): MD				
9a. FACILITY NAME (If not institution, give street and number): J.L. DEACON Hosp/med Center	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: City		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 630 Washington Blvd.		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 X Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Never Worked	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): William H. Deckert		18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara B. Zeigler	
19a. INFORMANT'S NAME (Type/Print): Mary Young	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5408 Park Road Baltimore, Maryland 21225		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Richard Gonce	22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Aspiration Pneumonia	1 day
DUE TO (OR AS A CONSEQUENCE OF): b.	Cerebrovascular Accident	1973
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Insufficency

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H.C. Muncie Asst. Med. Dir	29c. LICENSE NUMBER: D14622	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H.C. Muncie 600 S. Charles ST Balto, Md 21218		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23439

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Dickerson, Jr.
2. DATE OF DEATH (Month, Day, Year): 8-27-89
3. TIME OF DEATH: 5:34PM M
4. SOCIAL SECURITY NUMBER: 214-50-0207
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 41 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 5/24/48
8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): 2615 Edison Hgwy.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2615 EDISON HIGHWAY
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LONGSHOREMAN
16b. KIND OF BUSINESS/INDUSTRY: NA

17. FATHER'S NAME (First, Middle, Last): WILLIAM DICKERSON, SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA HOMER

19a. INFORMANT'S NAME (Type/Print): ERICKA DICKERSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 N. CHAPEL STREET/BALTO., DM 21231

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
20c. LOCATION — City or Town, State: ANNE ARUNDEL CO., MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Wilkins
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute narcotic intoxication	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [XX] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [XX] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [XX] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8-27-89 (FOUND)
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [XX] NO
28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FOUND: home UNKNOWN
28f. LOCATIDN (Street and Number or Rural Route Number, City or Town, State): FOUND: 2615 Edison Hgwy. Baltimore, Maryland

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, baltimore, MD 21201 VC
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23440
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JENNIE SADIE DEANGELIS
2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89
3. TIME OF DEATH: 12:04 AM
4. SOCIAL SECURITY NUMBER: 220-54-3054
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 06-24-08
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: HARFORD
10c. CITY, TOWN OR LOCATION: EDGEWOOD
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ● NO
10e. STREET AND NUMBER: 1901 HAWTHORNE ROAD
10f. ZIP CODE: 21040
10g. CITIZEN OF WHAT COUNTRY?: U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YEARS — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): DOMINICK CONAVALL
18. MOTHER'S NAME (First, Middle, Maiden Surname): JENNIE SCOLA
19a. INFORMANT'S NAME (Type/Print): JOSEPHINE JAKELSKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1901 HAWTHORNE RD. EDGEWOOD, MD 21040
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER CEMT. AUGUST 30, 1989
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: LEONARD J. RUCK INC. 5305 HARFORD RD BALTI MD 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Linda [illegible]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶ 8/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LINDA [illegible] 1604 Churchville Road Bel Air MD
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23441
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Greer Callaway Emory (Greer C. Emory)				2. DATE OF DEATH (Month, Day, Year): 8-17-89	3. TIME OF DEATH: 5:15 PM	
4. SOCIAL SECURITY NUMBER: 226-62-5407	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 27 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 27, 1962	8. BIRTHPLACE (State or Foreign Country): Virginia	
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Rockville			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 500 West Montgomery Ave.		10f. ZIP CODE: 20850		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress	16b. KIND OF BUSINESS/INDUSTRY: Sammy T.'s Restaurant				
17. FATHER'S NAME (First, Middle, Last): Samuel Thomas Emory	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sylvia Callaway					
19a. INFORMANT'S NAME (Type/Print): Samuel Thomas Emory	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Hawk Street, Fredericksburg, VA 22401					
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mercer Crematory	20c. LOCATION — City or Town, State: Fredericksburg, VA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J. Andrews for Mullins F.H.	22. NAME AND ADDRESS OF FACILITY: Mullins Funeral Service, 1621 Jefferson Davis Hwy., Fredericksburg, VA					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hanging	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John Tauber MD	D085466	▶ 8-17-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Tauber 8218 Wisconsin Ave Bethesda MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23442

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORCAS A ELLECAMP			2. DATE OF DEATH (Month, Day, Year): 08 22 89	3. TIME OF DEATH: 450 PM M
4. SOCIAL SECURITY NUMBER: 214-16-6019A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): DEC. 4, 1909	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: RIVERIA BEACH (PASADENA)	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8445 Church Rd.	10f. ZIP CODE: 21122	10g. CITIZEN OF WHAT COUNTRY?: U.S.A	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4 or 5+): —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TELEPHONE OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: PHONE CO	
17. FATHER'S NAME (First, Middle, Last): HARRY LONG		18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA	
19a. INFORMANT'S NAME (Type/Print): VIRGINIA BANDTHOLTZ	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7748 MEADOW Rd BALTO, Md 21122		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEM.	20c. LOCATION — City or Town, State: PIKESVILLE, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. M. Lowner	22. NAME AND ADDRESS OF FACILITY: McCULLY FUNERAL HOME 3204 MOUNTAIN Rd, PASADENA, Md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Shock
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Sepsis.
DUE TO (OR AS A CONSEQUENCE OF):
c. Intraabdominal Process.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Krishan K Singal M.D.	29c. LICENSE NUMBER: D36900	29d. DATE SIGNED (Month, Day, Year): ▶ 08/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
KRISHAN K. SINGAL, M.D. 7422 BALTIMORE-ANNAPOLIS BLVD GLEN BURNIE, MARYLAND 2106

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23443

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annemarie Karoline Fite		2. DATE OF DEATH (Month, Day, Year): August 26, 1989	3. TIME OF DEATH: 7:10 PM
4. SOCIAL SECURITY NUMBER: 268.34.8700	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 4, 1929
8. BIRTHPLACE (State or Foreign Country): Germany			
9a. FACILITY NAME (If not institution, give street and number): 509 Elizabeth Road	9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie	9c. COUNTY OF DEATH: Anne Arundel	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 509 Elizabeth Road	10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): NA	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teller	16b. KIND OF BUSINESS/INDUSTRY: Banking Industry	
17. FATHER'S NAME (First, Middle, Last): Georg Kenner	18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Troebs		
19a. INFORMANT'S NAME (Type/Print): Frederick L. Fite	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Crownsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leah M. Boss	22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, 1 Second Ave. S.W., Glen Burnie, Md. 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such ae cerdiec or reapiratory arreat, ahock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Spastic Quadriplegia	1983
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Upper motor neuron disorder (possibly "ALS")	1982
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Arnold-Chiari malformation, type I	congenital
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. —	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus, type

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO Contacted Dr. Seeger

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer	29c. LICENSE NUMBER: D05928	29d. DATE SIGNED (Month, Day, Year): ▶ Aug 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles W. Kinzer, MD, 1833 Forest Drive, Annapolis, MD 21401		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23444 REG. NO.

12

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SAMUEL D. GODWIN JR
2. DATE OF DEATH — MONTH: 8 DAY: 28 YEAR: 1989
3. TIME OF DEATH: 11:35 AM
4. SOCIAL SECURITY NUMBER: 218052410
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/28/1918
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor HOSPITAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD
9c. COUNTY OF DEATH: [illegible]

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: [illegible]
10c. CITY, TOWN OR LOCATION: Baltimore MD 21225
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1319 E Patapsco Ave
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY? AMERICA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tool Maker
16b. KIND OF BUSINESS/INDUSTRY: Martin Marietta

17. FATHER'S NAME (First, Middle, Last): Samuel D. Godwin Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elfrieda Klotsen

19a. INFORMANT'S NAME (Type/Print): Winnifred Godwin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1319 E. Patapsco Avenue Baltimore, Maryland 21225

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George J. Gonce
22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sepsis	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ASPIRATION PNEUMONIA	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	CVA	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SYED M A RIAZ

31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: [signature] Gisha Davidson-Randall

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23445
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROY LEE GOODWIN, JR.			2. DATE OF DEATH (Month, Day, Year): AUGUST 24 1989	3. TIME OF DEATH: 10:45 A M
4. SOCIAL SECURITY NUMBER: 212-56-9045	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/09/53	8. BIRTHPLACE (State or Foreign Country): BALTO., MD
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2048 ROBB STREET		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED	16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): ROY LEE GOODWIN, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELEANOR HARRISON	
19a. INFORMANT'S NAME (Type/Print): ELEANOR GOODWIN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1733 ORLEANS STREET/BALTIMORE, MD 21231	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTVIEW MEMORIAL PARK	20c. LOCATION — City or Town, State: DUNDALK, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony E. Ward Jr.		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	hypotension	10 mins
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	liver failure	3 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	alcohol abuse	10 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Yvonne Ottaviani	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): YVONNE OTTAVIANO MD 600 N. WOLFE ST. BALTIMORE MD 21205

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23446
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached/or used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET C. GEMMILL			2. DATE OF DEATH (Month, Day, Year): 8/26/89	3. TIME OF DEATH: 1:00 A M
4. SOCIAL SECURITY NUMBER: 218-09-7769	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5/27/17	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): MASON LORD/KEY HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH: ------	
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: ----	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 2000 ODELL AVENUE APT. 171		10f. ZIP CODE: 21237	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERICAL	16b. KIND OF BUSINESS/INDUSTRY: STATE OF MD.		
17. FATHER'S NAME (First, Middle, Last): WILLIAM RABENAU		18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE HERGENROTHER		
19a. INFORMANT'S NAME (Type/Print): CATHERINE MURN (DGHTR.)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8416 LOCH RAVEN BLVD., BALTO. MD. 21204		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE NATIONAL	20c. LOCATION — City or Town, State: BALTIMORE MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis, prob 2° pneumonia vs. pressure	Hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): pneumonia, prob aspiration	Days
	c. DUE TO (OR AS A CONSEQUENCE OF): pressure decubiti	Days
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: S/P multiple CVA's. mild dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Katrina J Loor MD	D25293	8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Beacham Center, 5200 Eastern Ave. Balto, Md. 21224

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	[signature]

DHMH-16 Rev 1/89

#11,FilmG658 12/11/89 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23447

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Melvin Andress Guthrie, Sr.

2. DATE OF DEATH (Month, Day, Year): August 25, 1989

3. TIME OF DEATH: 1934 PM

4. SOCIAL SECURITY NUMBER: 230.52.3135

5. SEX: 1 ☐ M 2 ☐ F (X)

6. AGE (In yrs. last birthday): 49 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Nov. 2, 1939

8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie

9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Anne Arundel

10c. CITY, TOWN OR LOCATION: Severn

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 217 Otis Drive

10f. ZIP CODE: 21144

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th — College (1-4 or 6+): NA

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman

16b. KIND OF BUSINESS/INDUSTRY: Architect of the Capital

17. FATHER'S NAME (First, Middle, Last): Raymond Worth Guthrie

18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Sloan

19a. INFORMANT'S NAME (Type/Print): Melvin Guthrie, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16617 Fern Place, Woodbridge, Va. 22192

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Farmville Adventist Cemetery

20c. LOCATION — City or Town, State: Farmville, Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leah Marie Boss

22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, 1 Second Ave.S.W., Glen Burnie, Md. 21061

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SHOCK — SECONDS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CERVICAL SPINE AND SKULL TRAUMA

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☑ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year): 8-25-89

26b. TIME OF INJURY: 1610 PM

26c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO

26d. DESCRIBE HOW INJURY OCCURED: FRONTSEAT UNBELTED PASS IN HEAD ON MVA

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HIGHWAY

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State): WEST BOUND DORSET ROAD GLEN BURNIE

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D33757

29d. DATE SIGNED (Month, Day, Year): ▶ 8-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 108 ASHEWTON ROAD SEVERNA PARK MD 21146

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23448

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NATHANIEL R. GARLAND			2. DATE OF DEATH (Month, Day, Year): AUGUST 23rd, 1989	3. TIME OF DEATH: 10:00 P. M
4. SOCIAL SECURITY NUMBER: 213 03 5843	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 25 1898	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): INNS OF EVERGREEN		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: ESSEX	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 333 BACK RIVER NECK ROAD		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: U. S. OF A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRINTER	16b. KIND OF BUSINESS/INDUSTRY: PRINTING SHOP	
17. FATHER'S NAME (First, Middle, Last): ARMSTEAD R. GARLAND		18. MOTHER'S NAME (First, Middle, Maiden Surname): MATILDA SAWYER	
19a. INFORMANT'S NAME (Type/Print): MRS. ADELENA ELMORE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4707 THREE OAKS ROAD BALTIMORE, MARYLAND 21208	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION CEMETERY 8/29/89	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Cardiopulmonary Arrest	—
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Chronic Congestive Heart Failure	month
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Severe Emphysema (C.O.P.D.)	years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of the Prostate
Recurrent Urinary Tract Infections
Recurrent Bronchitis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Albert B Bradley MD	29c. LICENSE NUMBER: D 00426	29d. DATE SIGNED (Month, Day, Year) ▶ AUGUST 28, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALBERT B. BRADLEY, M.D. 4900 BELAIR ROAD BALTIMORE, MARYLAND 21206

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23449

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William F. Hardy					2. DATE OF DEATH (Month, Day, Year): 8-21-89	3. TIME OF DEATH: 2:47PM M
4. SOCIAL SECURITY NUMBER: 216-16-1717	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 01-23-24	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2103 Hollins Ferry Road			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: ====	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: =====	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2103 Hollins Ferry Road		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman	16b. KIND OF BUSINESS/INDUSTRY: Maryland Glass
17. FATHER'S NAME (First, Middle, Last): William F. Hardy Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Farrel	
19a. INFORMANT'S NAME (Type/Print): Mary Warner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2615 Rittenhouse Avenue Baltimore, Md. 21230	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Gronnowski		22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alcoholic liver disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XXX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home XXX 5 Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: XXX 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
[ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23450 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Theodore Roosevelt Haynes		2. DATE OF DEATH (Month, Day, Year): 8 28 89	3. TIME OF DEATH: 9.10 pm
4. SOCIAL SECURITY NUMBER: 220-05-1864	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3 8 06
8. BIRTHPLACE (State or Foreign Country): Delaware			

9a. FACILITY NAME (If not institution, give street and number): 2730 Edmondson Ave.	9b. CITY, TOWN OR LOCATION OF DEATH: Balto. Md.	9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2730 Edmondson Ave.		10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY?: U.S.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Henry Haynes	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella		
19a. INFORMANT'S NAME (Type/Print): Shelton Haynes	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2730 Edmondson Ave. Balto. Md. 21223		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery	20c. LOCATION — City or Town, State: Landsdowne, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clifton M. Wainwright	22. NAME AND ADDRESS OF FACILITY: Wainwright Funeral Home 2700 Edmondson Ave. Balto. Md. 21223		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Mild congestive heart failure, Hypothyroidism Severe Dementia senile/multiinfarct.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) —	28b. TIME OF INJURY — M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED —	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) —	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) —	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Komal K. Dang MD	29c. LICENSE NUMBER: D18362	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KOMAL K. DANG M.D. 700 Washington Blvd Balto Md 21030.

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

item 7 08/30/89 jrd/per funeral home

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23451

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORIS C. HOLT			2. DATE OF DEATH (Month / Day / Year): 8 / 25 / 89	3. TIME OF DEATH: 9:11 P M
4. SOCIAL SECURITY NUMBER: 228 30 6002	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 1/30/1916	8. BIRTHPLACE (State or Foreign Country): N.C.
8a. FACILITY NAME (If not institution, give street and number): 1915 N. Bentalou Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: n/a
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1915 N. Bentalou St.		10f. ZIP CODE: 21216		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Sam Williams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Withers		
19a. INFORMANT'S NAME (Type/Print): Granville Docctor Holt		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1915 N. Bentalou St. Balto., Md. 21216		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus		20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton		22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on aach line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A COHSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A COHSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO (head only)	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYIHG PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICEHSE HUMBER	29d. DATE SIOHED (Month, Day, Year)
Margarita A. Korell, M.D.	OCME	8-26-89

30. HAME AHD ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street Baltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23452 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BIRDIE HOPKINS		2. DATE OF DEATH (Month / Day / Year): 8 / 26 / 89	3. TIME OF DEATH: 12:41 PM
4. SOCIAL SECURITY NUMBER: 251 02 4502	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 56 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): JUL. 26, 1933
8. BIRTHPLACE (State or Foreign Country): SOUTH CAROLINA			
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT			
10a. STATE: SOUTH CAROLINA	10b. COUNTY: EE COUNTY	10c. CITY, TOWN OR LOCATION: BISHOPVILLE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: ROUTE # 1 BOX # 108	10f. ZIP CODE: 29010	10g. CITIZEN OF WHAT COUNTRY?: U. S. OF A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ELEMENTARY; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC	16b. KIND OF BUSINESS/INDUSTRY: PRIVATE FAMILY	
17. FATHER'S NAME (First, Middle, Last): JAMES WILSON	18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE MAE WILSON		
19a. INFORMANT'S NAME (Type/Print): KATIE HOPKINS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ROUTE 1 BOX 108 BISHOPVILLE, SOUTH CAROLINA 29010		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW HOPE CEMETERY	20c. LOCATION — City or Town, State: BISHOPVILLE, S. C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lewis T. Gwynn	22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	Inspection	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wayne Ross Hall	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D.	111 Penn Street	Baltimore, MD. 21201
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23453 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARTHUR ALLEN JONES				2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89	3. TIME OF DEATH: 2 22 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10 5 03	8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): JENKINS MEMORIAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 823 McKEAN AVENUE		10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY?: US	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STEEL WORKER		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): JOSHUA JONES		18. MOTHER'S NAME (First, Middle, Maiden Surname): JOANNA UNKNOWN			
19a. INFORMANT'S NAME (Type/Print): VEOLA JACKSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1732 ALBERT DRIVE MITCHELLVILLE, MD. 20716			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WAKEFIELD CEMETERY		20c. LOCATION — City or Town, State: NORTH CAROLINA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Veola Jackson #281		22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 N. MONROE ST. 21217			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Atherosclerotic Coronary Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Senile Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Edmund P. Thurnau	D34957	8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDMUND P. THURNAU MD 3350 W. Hdens ave Balt MD 21229

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Tuttle-Sanders

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23454

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
BERLIN	W.	JONES	8 / 26 / 89	2:20 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-09-4419	1 ☑ M 2 ☐ F	93 YRS.		10/5/95	North Carolina

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
2210 Aiken Street	Baltimore	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland		Baltimore	1 ☑ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2210 Aiken Street	21218	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☑ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	Laborer	Fertilizer Factory

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Louis Jones	Jane ?

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eleanora Davis	2210 Aiken Street Balto. Md 21218

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Baltimore Cemetery	Balto. City, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Gloria Adams Jones	Marshall W. Jones, Jr. F.H.' P.A., 4101 Edmondson Ave. Balto. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO
Inspection	

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita A. Korell, M.D.	OCME	▶ 8-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, M.D. 111 Penn Street Baltimore, MD. 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Gina Knudson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23455
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELSIE M. JACOB			2. DATE OF DEATH (Month, Day, Year): 08 26 89	3. TIME OF DEATH: 0420 AM
4. SOCIAL SECURITY NUMBER: 216-03-3287	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 30 1911	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): MERCY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: -----

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: ----	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3932 KENYON AVENUE		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/a; College (1-4 or 5+): N/a	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): GEORGE RECKLINE		18. MOTHER'S NAME (First, Middle, Maiden Surname): CHARLOTTE KELLER	
19a. INFORMANT'S NAME (Type/Print): CHARLES JACOB (HUSBAND)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3932 KENYON AVENUE BALTIMORE MD. 21213	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore, Md. 21213	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer - Adenocarcinoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Harold 301 St. Paul Place Baltimore, Md. 21202		
31. DATE FILED: AUG 29 1989	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

89 23456

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CAPTAIN CONIWAY KNIGHT					2. DATE OF DEATH (Month, Day, Year): AUGUST 28, 1989	3. TIME OF DEATH: 2:20A M
4. SOCIAL SECURITY NUMBER: 213-07-0620	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5/09/11	8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1517 N. EDEN STREET		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BETHLEHEM STEEL	16b. KIND OF BUSINESS/INDUSTRY: RETIRED	
17. FATHER'S NAME (First, Middle, Last): WILLIAM KNIGHT		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLEN JENNINGS	
19a. INFORMANT'S NAME (Type/Print): MARY FLOWERS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1517 N. EDEN STREET/BALTO., MD 21213	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Wellbaum		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	respiratory arrest	3 minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	left pleural effusion	1 month
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan K. Duncan MD	29c. LICENSE NUMBER: E9890	29d. DATE SIGNED (Month, Day, Year): 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan K. Duncan MD 600 North Wolfe, Baltimore MD 21205

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5 033 50 18 A

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23457
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARA KLEPPERT					2. DATE OF DEATH (Month, Day, Year): 8/27/89		3. TIME OF DEATH: 12:20 AM
4. SOCIAL SECURITY NUMBER: 213-14-2770	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03/28/09		8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY			9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT							
10a. STATE: MD.	10b. COUNTY:		10c. CITY, TOWN OR LOCATION: BALTIMORE CITY			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: 3703 MT. PLEASANT AVE.			10f. ZIP CODE: 21224			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): -----			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nursing Assistant			16b. KIND OF BUSINESS/INDUSTRY: Nursing Home	
17. FATHER'S NAME (First, Middle, Last): Temple			18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown				
19a. INFORMANT'S NAME (Type/Print): Benjamin R. Kleppert			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3703 Mt. Pleasant Avenue Balto. Md. 21224				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery			20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph N. Zannino Jr.			22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street 21224				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Disputed sepsis	SUSPECTED SEPSIS	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. Cellulitis	CELLULITIS	2 days
DUE TO (OR AS A CONSEQUENCE OF): c. Congestive heart failure	CONGESTIVE HEART FAILURE	
DUE TO (OR AS A CONSEQUENCE OF): d. COPD	COPD	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M. ZUGHAYB MD		8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. M. ZUGHAYB, M.D. CHURCH HOSPITAL
M. ZUGHAYB MD, 6933-C DONACHIC RD, BALTO MD 21239

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randolph

DHMH-16 Rev 1/89

89 23458

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAISY LOU KELLY			2. DATE OF DEATH (Month, Day, Year): 08/22/989	3. TIME OF DEATH: 1:15P M
4. SOCIAL SECURITY NUMBER: 204-16-8441	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug 1, 1923	8. BIRTHPLACE (State or Foreign Country): Pa
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: Pa	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: RD1 Meyersdale	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: DR1	10f. ZIP CODE: 15552	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): John Winner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy Rugg	
19a. INFORMANT'S NAME (Type/Print): Linda Blank		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Mt Savage , Md. 21545	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Highland	20c. LOCATION — City or Town, State: Garrett, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: M. Ray Leckemby Funeral Home 203 North Street Meyersdale, Pa 15552	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Widespread Histrocytic Lymphoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Severe pancytopenia
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Mehanna	29c. LICENSE NUMBER: D-17526	29d. DATE SIGNED (Month, Day, Year) ▶ 8-23-89

30. NAME AND ADDRESS OF ~~PERSON WHO COMPLETED~~ CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JOHN MEHANNA 909-B SETON DRIVE CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Items 23 thru 27 per ME G-655
9-26-89 cm Item:28a-28f G-656 10-6-89 cm ME

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23459

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Irvin Klemkowski Sr.				2. DATE OF DEATH (Month, Day, Year): 8-24-89	3. TIME OF DEATH: 12:17AM M
4. SOCIAL SECURITY NUMBER: 213-20-6923	5. SEX: XX 1 M 2 F	6. AGE (In yrs. last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 25, 1928
					8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: --------	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: --------	10c. CITY, TOWN OR LOCATION: Balto,City,Md.		10d. INSIDE CITY LIMITS? XX 1 YES 2 NO	
10e. STREET AND NUMBER: 1120 E.Fort Ave.		10f. ZIP CODE: 21230		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 XNO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th.Grade; College (1-4 or 5+): --------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Checker		16b. KIND OF BUSINESS/INDUSTRY: Longshoreman	
17. FATHER'S NAME (First, Middle, Last): Henry P. Klemkowski				18. MOTHER'S NAME (First, Middle, Maiden Surname): Estelle Drymala Klemkowski	
19a. INFORMANT'S NAME (Type/Print): Mrs.Rosemary Klemkowski		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1120 E.Fort Ave.Balto.Md.21230			
20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery		20c. LOCATION — City or Town, State: Balto.A.A.Co.Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stanley M. Loewner		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home,130 E.Fort Ave. Balto.Md.21230			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Contact Gun Shot Wound to Head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XXX 1 YES 2 NO	XXX 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX 1 YES 2 NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XX 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 X Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-18-89	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURED: Unknown
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): STREET			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1120 E. Fort Avenue Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita A. Korell	OCME	▶ 8-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23460

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
RICHARD	HOWARD	KESTLER	Aug. 26 89	11:50PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214 16 3360	1 [X] M 2 [ ] F	67 YRS.			Feb. 23 22	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
108 Old Landing Road	Ocean City, Maryland	Worcester

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Worcester	Ocean City, Maryland	[X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
108 Old Landing Road	21842	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
9 th Grade	None	Telephone Communications	Dept. of Defense

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
EDWARD L. KESTLER	MARGARET THOMAS

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alverta O. Kestler	108 Old Landing Rd., Ocean City, Md. 21842

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
[X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GLEN HAVEN Memorial Park	GLEN BURNIE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	Singleton Funeral Home 1 2nd Ave. S.W. at Crain Hwy., Glen Burnie, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer of Lung	1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D21640	▶ 08/ 27/ 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. William J. Nagel, M.D. Peninsula General Hosp., Salisbury, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	[signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23461

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis Henry Lindner, Sr.

2. DATE OF DEATH (Month, Day, Year): August 27, 1989

3. TIME OF DEATH: 1:20 A M

4. SOCIAL SECURITY NUMBER: 215-09-4853

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

7. DATE OF BIRTH (Month, Day, Year): January 30, 1907

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Manor Care Ruxton

9b. CITY, TOWN OR LOCATION OF DEATH: Towson

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 1723 Ramblewood Road

10f. ZIP CODE: 21239

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES: x

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): n/a
College (1-4 or 5+): n/a

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist

16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel

17. FATHER'S NAME (First, Middle, Last): Carl Frank Lindner

18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Katherine Hottenbacher

19a. INFORMANT'S NAME (Type/Print): Louis H. Lindner, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9903 Gunforge Road, Perry Hall, Maryland 21128

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, Inc.
9705 Belair Road, Baltimore, Maryland 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIO-PULMONARY ARREST	IMMED.
DUE TO (OR AS A CONSEQUENCE OF): b.	CARCINOMATOSIS & PNEUMONIA	3 WKS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	METASTATIC CANCER OF COLON &	1 YRS
d.	CANCER OF BLADDER	1 YRS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Henri T. Voorstad, M.D.

29c. LICENSE NUMBER: D11064

29d. DATE SIGNED (Month, Day, Year): 8-28-1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HENRI T. VOORSTAD, MD, 7600 OSLER DR. TOWSON, MD. 21204

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23462
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): OTTO A. LAGE			2. DATE OF DEATH (Month, Day, Year): 8 26 89	3. TIME OF DEATH: 715 A M
4. SOCIAL SECURITY NUMBER: 216-09-9615	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): JAN. 27 1901	8. BIRTHPLACE (State or Foreign Country): GERMANY
9a. FACILITY NAME (If not institution, give street and number): JENKINS MEMORIAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: -----
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: -----	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3446 CARDENAS AVENUE		10f. ZIP CODE: 21213		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COPPERSMITH		16b. KIND OF BUSINESS/INDUSTRY: U.S. COAST GUARD
17. FATHER'S NAME (First, Middle, Last): GUSTAV LAGE			18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE BEUSCH	
19a. INFORMANT'S NAME (Type/Print): (FRIEND) FATHER DANIEL McGUIRE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): LOYOLA COLLEGE, BALTIMORE, MD. 21210		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY		20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore, Md. 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	Weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): —

28b. TIME OF INJURY: — M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED: —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John F. Hartman, MD	D 05403	▶ 8-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN F. HARTMAN M.D. JENKINS M.H. 1000 S. Caton Ave 21229

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23463
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEGRAND, UAREL (UREAL)			2. DATE OF DEATH (Month / Day / Year): 8 / 24 / 89	3. TIME OF DEATH: 12 [illegible] P M
4. SOCIAL SECURITY NUMBER: 215-46-6945	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 41 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-18-48	8. BIRTHPLACE (State or Foreign Country): N Carolina
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Md (21224)		9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Balto	10c. CITY, TOWN OR LOCATION: Dundalk (Maryland)	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 707 N. Avondale Rd Dundalk Md		10f. ZIP CODE: (21222)	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed	16b. KIND OF BUSINESS/INDUSTRY: Food Service

17. FATHER'S NAME (First, Middle, Last): Robert J. LeGrand, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Fowler
19a. INFORMANT'S NAME (Type/Print): Robert J. LeGrand, Sr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 N. Avondale Rd. Balto., Md. 21222

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus	20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton	22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Probable Pulmonary Embolus	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SIP large basal ganglia bleed

	24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James Kaiser	29c. LICENSE NUMBER: D38761	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23464 — REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred KARCZMAREK (KARCZMAREK)				2. DATE OF DEATH (Month, Day, Year): 8 26 89	3. TIME OF DEATH: 1554 M
4. SOCIAL SECURITY NUMBER: 219 16 2999A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 97 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 04/29/12	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Manor		9b. CITY, TOWN OR LOCATION OF DEATH: BALTO		9c. COUNTY OF DEATH: Baltimore City	
RESIDENCE OF DECEDENT					
10a. STATE: MD.	10b. COUNTY: Balto County	10c. CITY, TOWN OR LOCATION: BALTO		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 1215 64th St		10f. ZIP CODE: 21237.		10g. CITIZEN OF WHAT COUNTRY? USA.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: W	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY: —	
17. FATHER'S NAME (First, Middle, Last): JOHN CHEHANSKY		18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA PAULISCHAK			
19a. INFORMANT'S NAME (Type/Print): STANLEYA KARCZMAREK		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1215 64TH ST. BALTO MD 21237			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST STANISLAUS CEM		20c. LOCATION — City or Town, State: BALTO MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward J Weber		22. NAME AND ADDRESS OF FACILITY: EDWARD J WEBER F.H. 401 S CHESTER ST.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY INSUFFICIENCY	≅ 1 DAY
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. OVERWHELMING SEPSIS	≅ 1 DAY
DUE TO (OR AS A CONSEQUENCE OF):		
	c. ENTEROCUTANEOUS FISTULA	3 WEEKS
DUE TO (OR AS A CONSEQUENCE OF):		
	d. —	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Calvin E. Jones M.D.	D06251	26 Aug 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CALVIN E. JONES M.D. DEPT. SURGERY, FRANCIS SCOTT KEY MED CTR.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 23465

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leroy W. Merson			2. DATE OF DEATH (Month / Day / Year): 8 / 25 / 1989	3. TIME OF DEATH: 0320 A M
4. SOCIAL SECURITY NUMBER: 213-01-7649	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-26-12	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: ======
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7863 Crillery Road		10f. ZIP CODE: 21061		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd Grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver		16b. KIND OF BUSINESS/INDUSTRY: Brewery
17. FATHER'S NAME (First, Middle, Last): William Merson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Etta King		
19a. INFORMANT'S NAME (Type/Print): Wanda Sponaugle		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6642 Whitmore Court Apt B173 Glen Burnie, Md.21061		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc.		20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C Davis		22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Bilateral pneumonia — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic prostate carcinoma — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic Renal Faidure — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [✓] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
I.M. Ndukwe, MD		▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ikeadi M. Ndukwe Harbor Hospital Center Baltimore, MD 21230

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23466

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

MARGARET A. McGRAW

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret A McGraw			2. DATE OF DEATH Month: Aug. Day: 27 Year: 89	3. TIME OF DEATH: 140 A M
4. SOCIAL SECURITY NUMBER: 216-46-3941	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-17-07	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Collingswood	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: BOYDS	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: BUCK LODGE ROAD POBOX 16		10f. ZIP CODE: 20841	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR	16b. KIND OF BUSINESS/INDUSTRY: TELEPHONE CO.	
17. FATHER'S NAME (First, Middle, Last): ROGER BROOKE ADAMS	18. MOTHER'S NAME (First, Middle, Maiden Surname): LELIA JOHNSON		
19a. INFORMANT'S NAME (Type/Print): JOHN McGRAW	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5603 OVERLEA ROAD BETHESDA, MD. 20816		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY	20c. LOCATION — City or Town, State: ALEXANDRIA, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Muriel H. Barber	22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE ROAD LAYTONSVILLE, MD. 20882		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. cerebrovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John R Melnick	29c. LICENSE NUMBER: D19294	29d. DATE SIGNED (Month, Day, Year): 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Melnick - 911 Russell Ave. Gaithersburg, Md 20879

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 20b film G655 9-06-89 I.J.

89 23467

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN MILBURN			2. DATE OF DEATH (Month, Day, Year): 8 27 89	3. TIME OF DEATH: 7A M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 33 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12 15 55	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3501 MEMLO DRIVE		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: US
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): JOHN MILBURN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH LOUDEN	
19a. INFORMANT'S NAME (Type/Print): ELIZABETH MILBURN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3501 MEMLO DRIVE 21215	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. DRUID RIDGE CEMETERY MARYLAND NATIONAL MEM. PK.	20c. LOCATION — City or Town, State: LAUREL, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dorietha Hector #281		22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 N. MONROE STREET 21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrest, cardiogenic shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pulmonary edema

DUE TO (OR AS A CONSEQUENCE OF):

c. CHF Hypertension

DUE TO (OR AS A CONSEQUENCE OF):

d. Alcoholism

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sher A Hashmi MD	29c. LICENSE NUMBER: D24648	29d. DATE SIGNED (Month, Day, Year): 8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHER A HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMORE 21216

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

89 23468

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER J MICHAELKIEWICZ				2. DATE OF DEATH (Month, Day, Year): 8 / 27 / 89	3. TIME OF DEATH: 8:30 A.M
4. SOCIAL SECURITY NUMBER: 219 14 0788	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7/11/25	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): HOMEWOOD HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTO		9c. COUNTY OF DEATH: —	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: BALTO	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 2200 FLEET ST		10f. ZIP CODE: 21231	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: W

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMAN	16b. KIND OF BUSINESS/INDUSTRY: TUG BOAT	
17. FATHER'S NAME (First, Middle, Last): UnKnown MICHAELKIEWICZ		18. MOTHER'S NAME (First, Middle, Maiden Surname): UnKnown	
19a. INFORMANT'S NAME (Type/Print): DOLORES LOWE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 CT. DRIVE JOPPA MD 21085	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or): GARRISON FORREST	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward J Weber		22. NAME AND ADDRESS OF FACILITY: EDWARD J WEBER F.H. 4015 CHESTER ST	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ANOXIC ENCEPHALOPATHY	5 wks.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEPTICEMIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. LIVER FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. RENAL FAILURE	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CARDIAC ARRHYMIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. C. Chouvalit, M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. C. CHOUVALIT, M.D., HOMEWOOD HOSPITAL CENTER, 2742 N. CHARLES ST.

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23469

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary A. MALKOWSKI
2. DATE OF DEATH (Month, Day, Year): 8 22 89
3. TIME OF DEATH: 7 25 PM
4. SOCIAL SECURITY NUMBER: 219-32-1732
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-15-03
8. BIRTHPLACE (State or Foreign Country): M D.
9a. FACILITY NAME (If not institution, give street and number): MASON F. LORD N. H.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: BALTO.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2023 GOUGH ST.
10f. ZIP CODE: 21231
10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5TH GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSE WIFE
16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): ANTHONY STANKIEWICZ
18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA UNKNOWN
19a. INFORMANT'S NAME (Type/Print): ALBERT MALKOWSKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10123 DAVENTRY DR. COCKEYSVILLE MD. 21030
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY ROSARY CEM.
20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David J. Weber
22. NAME AND ADDRESS OF FACILITY: EDWARD J. WEBER F.H. 401 S. CHESTER ST.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Gastrointestinal hemorrhage	hours
DUE TO (OR AS A CONSEQUENCE OF):	Etiology not determined	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Dementia, H/O Fracture R

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 3-89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURRED: subject fell downsteps
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2023 Gough Street

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John R Burton — AHA Phy
29c. LICENSE NUMBER: D01889
29d. DATE SIGNED (Month, Day, Year): 8-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN R BURTON MD FRANCIS SCOTT KEY MED CTR 4940 EASTERN 21224
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Thomas J. Miller

EDWARD J. MEEBER F.H. HOLS.
CHESAPEAKE

Holy Rosary Cem. Balto, MD.

ALBERT Wasikowski 1023 Daventry Dr, MD 21030
COCKEYSVILLE

ANTHONY STANKIEWICS IDA UNKNOWN

5th GRADE HOUSE WIFE

X X WHITE

9093 Fonen St. 91931 USA

MD ——— BALTO. X

Mason F. Ford N.H. Balto. City

914-39-1139 X 85 11-12-03 MD.

Mary A. Wasikowski 8 32 84 1259

89 23470

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary M. Morriston
2. DATE OF DEATH (Month, Day, Year): Aug. 23, 1989
3. TIME OF DEATH: 8:30 P.M
4. SOCIAL SECURITY NUMBER: 214-80-5942
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 99 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): April 17, 1890
8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Seton Hill Manor, Inc.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City, Md.
9c. COUNTY OF DEATH: ------

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: -------
10c. CITY, TOWN OR LOCATION: Balto. City, Md.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1155 Nanticoke St.
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: Sept. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd. Grade — College (1-4 or 5+): -----
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Levi B. Morgan
18. MOTHER'S NAME (First, Middle, Maiden Surname): Olive Buchanan
19a. INFORMANT'S NAME (Type/Print): Mrs. Carla Williams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1155 Nanticoke St. Balto. Md. 21230
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stanley M. Loguner
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrhythmia	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Atherosclerotic Cardio Vascular Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Fredric S. Sirkis M.D.
29c. LICENSE NUMBER: D22645
29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FREDRIC S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

10+1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23471 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRY IRVING MILLER JR.
2. DATE OF DEATH: Month: AUGUST Day: 19 Year: 1989
3. TIME OF DEATH: 11 08 AM
4. SOCIAL SECURITY NUMBER: 219-28-4380
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 58 YRS. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7. DATE OF BIRTH (Month, Day, Year): 6-03-1931
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSP.
9b. CITY, TOWN OR LOCATION OF DEATH: ROSEDALE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: HARFORD
10c. CITY, TOWN OR LOCATION: PYLESVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 262 WHEELER SCHOOL RD.
10f. ZIP CODE: 21132
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 1951 - 1955
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — ~~American Indian, Black, White, etc.~~ Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MACHINIST
16b. KIND OF BUSINESS/INDUSTRY: CONTINENTAL CAN
17. FATHER'S NAME (First, Middle, Last): HENRY I. MILLER, SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY V. BALLBACH
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PACKWOOD CEM.
20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey F. Gain
22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ~~48~~ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ~~Acute~~ Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death: 9 MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO
25. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
25a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley Felsen M.D. DEPUTY MEDICAL EXAMINER
29c. LICENSE NUMBER: 001085
29d. DATE SIGNED (Month, Day, Year): ▶ Aug 19 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): STANLEY Z. FELSEN M.D. 11 E. Chase St 21202
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23472
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JEAN MARIE MORROW			2. DATE OF DEATH (Month, Day, Year): Aug 18 1989	3. TIME OF DEATH: 1010 A.M.
4. SOCIAL SECURITY NUMBER: 187-12-2920	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 22, 1922	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): 12 MELKEN CT.		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTO. CO.
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: BALTO. CO.	10c. CITY, TOWN OR LOCATION: FULLERTON		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 12 MELKEN CT.		10f. ZIP CODE: 21236		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SPEECH + LANG.		16b. KIND OF BUSINESS/INDUSTRY: SCHOOL TEACHER
17. FATHER'S NAME (First, Middle, Last): JOHN YODZIS		18. MOTHER'S NAME (First, Middle, Maiden Surname): MAGDALEN NOWOSATKO		
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OUR MOTHER OF CONSOLATION CEM.		20c. LOCATION — City or Town, State: MT. CARMEL, PA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey L. Fair		22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES 2325 YORK RD. TIMONIUM, MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ___ DUE TO (OR AS A CONSEQUENCE OF):

c. ___ DUE TO (OR AS A CONSEQUENCE OF):

d. ___

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Stanley Felsenberg Deputy Medical Examiner	D01085	▶ Aug 19, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY Z. FELSENBERG MD 11 E. Chase St 21202

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-15 Rev 1/89

ROBERT BENJAMIN MERRYMAN, SR.

7

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23473
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT B MERRYMAN, SR.			2. DATE OF DEATH (Month, Day, Year): 08 24 1989	3. TIME OF DEATH: 7:35P M
4. SOCIAL SECURITY NUMBER: 220 07 1272	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02/11/1911	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: LOCKEYSVILLE		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1011 MISTY LYNN CIRCLE		10f. ZIP CODE: 21030		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARPENTER		16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE COUNTY
17. FATHER'S NAME (First, Middle, Last): WILLIAM F. MERRYMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE BULL		
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JESSOPS CEMETERY		20c. LOCATION — City or Town, State: SPARKS, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES, 2325 YORK ROAD - TIMONIUM		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIOPULMONARY ARREST	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	MYOCARDIAL INFARCTION	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	CORONARY ARTERY DISEASE	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mahmoud Nemazee M.D.		8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MAHMOUD NEMAZEE M.D., G.B.M.C., 6701 N. CHARLES STREET, BALTIMORE, MD. 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23474

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILDRED J. McDONALD

2. DATE OF DEATH (Month, Day, Year): 8 / 23 / 89

3. TIME OF DEATH: 10:00 AM

4. SOCIAL SECURITY NUMBER: 213-34-1614

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 80 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 7/14/09

8. BIRTHPLACE (State or Foreign Country): TENN.

9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, MD

9c. COUNTY OF DEATH: BALTO.

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: BALTO.

10c. CITY, TOWN OR LOCATION: TOWSON

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 5 FELLOWSHIP CT. APT E

10f. ZIP CODE: 21204

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th Grade
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: Home

17. FATHER'S NAME (First, Middle, Last): Elmer Africa

16. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Unknown

19a. INFORMANT'S NAME (Type/Print): Barbara Gradet

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 Central Avenue Towson, Maryland 21204

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Services

20c. LOCATION — City or Town, State: Hampstead, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature]

22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc
8728 Liberty Road Randallstown, MD 21133

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PERITONITIS	DAYS
DUE TO (OR AS A CONSEQUENCE OF): b.	DEHISCENCE OF ILEO-~~COCAL~~ COLIC ANASTAMOSIS	DAYS
DUE TO (OR AS A CONSEQUENCE OF): c.	STATUS POST ILEO-COLIC RESECTION FOR CECAL CARCINOMA	13 DAYS
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ARTERIOSCLEROTIC CARDIOVASC. DISEASE, INCLUDING MESENTERIC ARTERIAL SUPPLY. EMPHYSEMA. ADULT ONSET DIABETES MELLITUS.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], STAFF PATHOLOGIST

29c. LICENSE NUMBER: D 14873

29d. DATE SIGNED (Month, Day, Year) ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES W. EAGAN, JR., MD, DEPT OF PATH. ST JOSEPH HOSP, TOWSON MD

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Judy Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23475
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES JOSEPH MANNING, SR				2. DATE OF DEATH: MONTH August DAY 26 YEAR 1989	3. TIME OF DEATH: 345 AM
4. SOCIAL SECURITY NUMBER: 215.10.4091	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 14, 1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 139 Olan Drive		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber	16b. KIND OF BUSINESS/INDUSTRY: Local Union
17. FATHER'S NAME (First, Middle, Last): Charles H. Manning		18. MOTHER'S NAME (First, Middle, Maiden Surname): Freida Wagner	
19a. INFORMANT'S NAME (Type/Print): Janice Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7932 Roxbury Drive, Glen Burnie, Md. 21061	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery	20c. LOCATION — City or Town, State: Brooklyn, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leah M. Boos		22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Maryland	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Respiratory Failure	9 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Advanced Lung Cancer	14 months
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.	29c. LICENSE NUMBER: D20431	29d. DATE SIGNED (Month, Day, Year) ▶ 8-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LONG S. HSU, M.D. 300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23476

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EARL ALLEN MARSHALL, SR.		2. DATE OF DEATH Month: 08 Day: 22 Year: 89	3. TIME OF DEATH: 1225 M
4. SOCIAL SECURITY NUMBER: 219-16-8612 A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): 12-19-1911
8. BIRTHPLACE (State or Foreign Country): PENNSYVLANIA			
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: EDGEMERE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7840 DENTON AVENUE	10f. ZIP CODE: 21219	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1931-1932	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGH SCHOOL; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WELDER	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): WILLIAM MARSHALL	18. MOTHER'S NAME (First, Middle, Maiden Surname): SADIE LEHR	
19a. INFORMANT'S NAME (Type/Print): DORIS L. MARSHALL	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7840 DENTON AVENUE BALTIMORE, MARYLAND 21219	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEM. 8-25-1989	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott P. Gardner	22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVE. DUNDALK, MARYLAND 21222	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gastrointestinal bleed - upper GI tract — n/week
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Oliguric Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(A)LL pneumonia
Urinary tract infection

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Christopher K. McQuitty MD Francis Scott Key Medical Center		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23477

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Pearl Nunn			2. DATE OF DEATH: MONTH 8 DAY 28 YEAR 89	3. TIME OF DEATH: 930 AM M
4. SOCIAL SECURITY NUMBER: 246-07-5046	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 107 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-27-1882	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): 1104 N. MONTFORD AVE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTO	9c. COUNTY OF DEATH: —	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO	
10e. STREET AND NUMBER: 1104 N. MONTFORD AVE		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): H/W	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): ARMSTEAD WADE		18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH CUMMINGHAM		
19a. INFORMANT'S NAME (Type/Print): MARY SOTO		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1104 MONTFORD AVE BALTO MD 21213		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT SINIA BAPTIST Church yard	20c. LOCATION — City or Town, State: DURHAM CO.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home		22. NAME AND ADDRESS OF FACILITY: 1129 N. CAROLINE ST.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Pulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Cozzens MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): The Edmonson Pelham Center Eastern Ave Baltimore, MD 21224		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: [illegible] Randall	

DNMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23478

15

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel S. Oyler (Mabel S. Oyler)			2. DATE OF DEATH (Month, Day, Year): 08 26 89	3. TIME OF DEATH: 5 30 PM
4. SOCIAL SECURITY NUMBER: 868-25-9861	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 12, 1907	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis MD	9c. COUNTY OF DEATH: AA Anne Arundel	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 946 Ship's Bell Court		10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John Sturges		18. MOTHER'S NAME (First, Middle, Maiden Surname): Unobtainable	
19a. INFORMANT'S NAME (Type/Print): Janie Farris		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2, Box 159, Marshall, Va. 22115	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. W. Robinson		22. NAME AND ADDRESS OF FACILITY: 171 W. Maple Avenue Money & King Funeral Home-Vienna, Virginia	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA — intracrant. bleed.	
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: age.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Tom Walden MD	29c. LICENSE NUMBER: D24768	29d. DATE SIGNED (Month, Day, Year) ▶ 8-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DABBS — 703 Giddings, Annapolis, Md

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23479 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ethel V. Pulliam			2. DATE OF DEATH (Month, Day, Year): August 22 1989	3. TIME OF DEATH: 4:45 A M
4. SOCIAL SECURITY NUMBER: 235-60-3198	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb, 18, 1905	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Moran Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Westernport	9c. COUNTY OF DEATH: Allegany	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Westernport	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 200 Clayton Avenue		10f. ZIP CODE: 21562	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical Worker	16b. KIND OF BUSINESS/INDUSTRY: State Government WV Department of Highways
17. FATHER'S NAME (First, Middle, Last): Douglas Stanton		18. MOTHER'S NAME (First, Middle, Maiden Surname): Della (unavailable)	
19a. INFORMANT'S NAME (Type/Print): Karol Robey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 953 Braddock Road, Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Queens Point Cemetery	20c. LOCATION — City or Town, State: Keyser, West Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William B. Clark MO0827		22. NAME AND ADDRESS OF FACILITY: Rotruck Funeral Home 85 South Main Street, Keyser, WV 26726	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septicemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Aspiration	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Parkinson's Disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ca of breast.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D21244	29d. DATE SIGNED (Month, Day, Year): 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jesus Tan Frostburg Plaza Frostburg, MD 21532		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23480

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE PETTEWAY				2. DATE OF DEATH (Month, Day, Year): 08 20 89	3. TIME OF DEATH: 7:10 P M
4. SOCIAL SECURITY NUMBER: 242097258	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07/04/14	8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md		9c. COUNTY OF DEATH: Baltimore City	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND		BALTIMORE	1 X YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2504 HOLLINS STREET	21223	US

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 X NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
7th			RAILROAD

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
GEORGE PETTEWAY	SARAH JOYNER

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CHARMAINE PETTEWAY	2504 HOLLINS ST. BALTIMORE, MD. 21223

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Garrison Forest Vet	Owings Mills, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY
▶ Veronica Lester	#281	E.L. PHILLIPS 1721 N. MONROE STREET 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiorespiratory arrest	7:10 p.m.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebral Vascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Multiple Diabetic	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 X NO	HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRISE HOW INJURY OCCURED
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Charles Moore MD	D35330	▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Gina Davidson-Randall

DHMH-16 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23481

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MADALINE S PRINGLE / Madeline S.Pringle			2. DATE OF DEATH (Month / Day / Year): 8 / 26 / 89	3. TIME OF DEATH: 1 15 A M
4. SOCIAL SECURITY NUMBER: 220-22-2181	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-14-28	8. BIRTHPLACE (State or Foreign Country): W.Virginia
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Balto.City,Md.		9c. COUNTY OF DEATH: ------

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: --------	10c. CITY, TOWN OR LOCATION: Balto.City,Md.	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 183 Westphal Place Balto		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cabinet Maker	16b. KIND OF BUSINESS/INDUSTRY: Laminating Co.	
17. FATHER'S NAME (First, Middle, Last): Casper ---- George		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dara L.Dugger Fawley	
19a. INFORMANT'S NAME (Type/Print): Mr.George L.Pringle		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1836 Westphal Place,Balto.Md.21230	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crestlawn Cemetery	20c. LOCATION — City or Town, State: Howard Co.Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S.M.Loewner		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home,130 E.Fort Ave. Balto.Md.21230	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrhythmia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cor Pulmonale	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic Obstructive Pulmonary Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cushingoid

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard E. [illegible] MD	29c. LICENSE NUMBER: DO 25 19	29d. DATE SIGNED (Month, Day, Year): ▶ Aug-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4710 Pennington Ave Baltimore Md		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: [illegible]	

DHMH-18 Rev 1/89

89 23482

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial, cremation, or removal. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS A REED			2. DATE OF DEATH (Month, Day, Year): AUGUST 24, 1989	3. TIME OF DEATH: 7:50 A M
4. SOCIAL SECURITY NUMBER: 217-07-9058	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb.10,1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Federalsburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: Rt.3 Box 264		10f. ZIP CODE: 21632	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 9	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman	16b. KIND OF BUSINESS/INDUSTRY: Baltimore Oxygen Co.
17. FATHER'S NAME (First, Middle, Last): John Reed		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Miller	
19a. INFORMANT'S NAME (Type/Print): Robert J. Reed		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3873 Old Columbia Pike, Ellicott City, MD 21043	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Washington Crematory	20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535		22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home Ellicott City, Maryland 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ADENOCARCINOMA, METASTATIC	2 WEEKS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: GANGRENE LEFT FOOT

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gregory Kalemkerian MD	29c. LICENSE NUMBER: D38494	29d. DATE SIGNED (Month, Day, Year): 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGORY KALEMKERIAN 600 N. WOLFE RD., BALTIMORE, MD 21211

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

OMMH-16 Rev 1/89

89 23483

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles L. Rider			2. DATE OF DEATH (Month, Day, Year): 8-24-89	3. TIME OF DEATH: 11:10 P.M.
4. SOCIAL SECURITY NUMBER: 213-26-8874	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06/09/30	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: BAltimore	10c. CITY, TOWN OR LOCATION: Parkville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1730 Yakona Rd.	10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: Korea	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Roofer	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Benjamium Rider		18. MOTHER'S NAME (First, Middle, Maiden Surname): Arrmenta DeHaven	
19a. INFORMANT'S NAME (Type/Print): Mrs. Vasso Rider	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1730 Yakona Rd. Baltimore, Md. 21234		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greek Cemetery 8/28/89	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L Hartsock Jr	22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Non Hodgkin's lymphoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acquired immune-deficiency	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Natividad D. de Leon, M.D.	29c. LICENSE NUMBER: D 19508	29d. DATE SIGNED (Month, Day, Year) ▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NATIVIDAD D. DE LEON, C/O ST. JOSEPH HOSPITAL, TOWSON, MD-21204

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Landis

DHMH-16 Rev 1/89

ITEM #4 FILM #g655 9/7/89 PER: FH. /J. A.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23484

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna D. Rittershofer		2. DATE OF DEATH (Month, Day, Year): 8 26 89	3. TIME OF DEATH: 12:18 M
4. SOCIAL SECURITY NO.: ~~217-60-1622~~ ~~217-60-1110~~	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 18, 1908
8. BIRTHPLACE (State or Foreign Country): Md.			
9a. FACILITY NAME (If not institution, give street and number): St Joseph Hosp	9b. CITY, TOWN OR LOCATION OF DEATH: MARYLAND, TOWSON	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7912 Old Harford Road	10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Otto Ludwig	18. MOTHER'S NAME (First, Middle, Maiden Surname): Augusta	
19a. INFORMANT'S NAME (Type/Print): Frank H. Rittershofer	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7912 Old Harford Road Baltimore, Maryland 21234	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount August 28, 1989	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Gladden James F. Gladden	22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck Inc. 5305 Harford Baltimore, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications ... caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY EDEMA — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. LARGE (R) PLEURAL EFFUSION — DUE TO (OR AS A CONSEQUENCE OF):	
	c. DEEP VEIN THROMBOSIS — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D33215	29d. DATE SIGNED (Month, Day, Year): ▶ 08/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Dawson	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23485

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Arth Snyder				2. DATE OF DEATH (Month, Day, Year): 08 24 89	3. TIME OF DEATH: 11:30 PM
4. SOCIAL SECURITY NUMBER: 213-32-6939	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08-18-35	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Ctr			9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince Georges Co

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Riviera Beach	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 214 Glen Road		10f. ZIP CODE: 21122	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Barber	16b. KIND OF BUSINESS/INDUSTRY: Self-Employed	
17. FATHER'S NAME (First, Middle, Last): Robert Snyder		18. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice Harding	
19a. INFORMANT'S NAME (Type/Print): Robert C. Snyder	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Stonemark Court Apt. 6 Owings Mills, Md. 21117		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Brooklyn Park, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C Davis	22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SMALL CELL CARCINOMA OF	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. LUNG.	3 months
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ACUTE RESPIRATORY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Krishan M. Mathur MD	D28352	▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KRISHAN M. MATHUR MD 445 Ellenwood Drive Laplata Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23486

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Stuples Baby Boy Michael James Stuples
2. DATE OF DEATH (Month, Day, Year): 08 26 89
3. TIME OF DEATH: 2 AM
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS 2 MIN. 8
7. DATE OF BIRTH (Month, Day, Year): 8/25/89
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Balt. Md
9c. COUNTY OF DEATH: ======

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ======
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 3002 Huron Street
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): David K. Stuples
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennifer L. Payne

19a. INFORMANT'S NAME (Type/Print): David K. Stuples
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3002 Huron Street Baltimore, Maryland 21230

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park
20c. LOCATION — City or Town, State: Glen Burnie, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C Davis
22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy.,Balto., Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. extreme prematurity

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R. Kolycius MD PL-II
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 8/28/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RITA KOLYCIUS ST. Agnes Hosp. Balt. Md 20229.

31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Taylor

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23487
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EARLLEAN H. STERN			2. DATE OF DEATH (Month, Day, Year): 8 / 25 / 89	3. TIME OF DEATH: 1:00 A M
4. SOCIAL SECURITY NUMBER: 216-30-0872	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/12/37	8. BIRTHPLACE (State or Foreign Country): BALTO., MD
9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1805 E. 29th STREET		10f. ZIP CODE: 21218		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED		16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): HARRY DORON		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY RICHARDSON		
19a. INFORMANT'S NAME (Type/Print): RAYMOND STERN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5601 SINCLAIR LANE/BALTIMORE, MD 21206 (APT B)		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY		20c. LOCATION — City or Town, State: ANNE ARUNDEL CO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Peripheral vascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Left Leg Amputation	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus; Hypertension; Chronic Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HILMER O. NEGRETE, UNION MEMORIAL HOSPITAL, BALTO-MD 21218

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23488

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LARRY H. SPILLMAN					2. DATE OF DEATH (Month, Day, Year): AUGUST 22, 1989		3. TIME OF DEATH: 4:30 A M
4. SOCIAL SECURITY NUMBER: 432-78-6506	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 44 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Apr. 15, 1945		8. BIRTHPLACE (State or Foreign Country): Arkansas
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY			9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE: Virginia	10b. COUNTY: Fairfax		10c. CITY, TOWN OR LOCATION: Vienna			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 9342 Sibelius Drive			10f. ZIP CODE: 22182			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES X		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney			16b. KIND OF BUSINESS/INDUSTRY: Law	
17. FATHER'S NAME (First, Middle, Last): George F. Spillman			18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Jane Holt				
19a. INFORMANT'S NAME (Type/Print): Christine Herold Spillman			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9342 Sibelius Drive, Vienna, Va. 22182				
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Flint Hill Cemetery			20c. LOCATION — City or Town, State: Oakton, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest L Myers			22. NAME AND ADDRESS OF FACILITY: Money & King Vienna Funeral Home, Inc. 171 W. Maple Ave., Vienna, Va. 22180				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	disseminated sepsis	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	immunosuppressive Rx S/P liver transplantation	5 months
DUE TO (OR AS A CONSEQUENCE OF): c.	renal failure	3 months
DUE TO (OR AS A CONSEQUENCE OF): d.	alcoholic cirrhosis	15 years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coagulopathy
GI Bleed
seizures

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATN (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
8/22/89	0430 AM	1 [ ] YES 2 [X] NO	Pt expired in hospital (ped.

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Hospital (ped.

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Johns Hopkins Hospital 600 N. Wolfe St Baltimore MD

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Atul R Hulyalkar MD	G0191	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ATUL R. HULYALKAR MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be mailed to the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23489
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY BOY COREY MICHAEL SINGLETON			2. DATE OF DEATH (Month, Day, Year): AUGUST 26, 1989	3. TIME OF DEATH: 5:53 P M
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 2, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): AUGUST 24, 1989	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: N/A	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: N/A	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO: N/A
10e. STREET AND NUMBER: N/A		10f. ZIP CODE: N/A	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): HOWARD F. SINGLETON		18. MOTHER'S NAME (First, Middle, Maiden Surname): KAREN SCHAUM	
19a. INFORMANT'S NAME (Type/Print): HOWARD F. SINGLETON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9000 NAYGALL ROAD, BALTIMORE, MARYLAND 21234	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEMORIAL GARDENS	20c. LOCATION — City or Town, State: TIMONIUM, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory srrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congenital Diaphragmatic Hernia and Probable Lung Hypoplasia	Birth
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Tracheogastric Fistula	Birth
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Pneumopericardium	60 hrs.
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Pneumothorax	7 mins.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and dus to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alice A. McKnight MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alice M. McKnight, M.D. Johns Hopkins Hospital CMSC-210 Baltimore, MD 21217		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23490
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH R. SIRBAUGH		2. DATE OF DEATH (Month / Day / Year): 8 / 25 / 89	3. TIME OF DEATH: 1045 A M
4. SOCIAL SECURITY NUMBER: 215-28-9822	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 28, 1929
8. BIRTHPLACE (State or Foreign Country): Md.			
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center	9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City, Md.	9c. COUNTY OF DEATH: -------	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: --------	10c. CITY, TOWN OR LOCATION: Balto. City, Md.	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1602 Olive St.	10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th. Grade; College (1-4 or 5+): ------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Martin F. Kiessling	18. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice --- Cooper		
19a. INFORMANT'S NAME (Type/Print): Mr. Calvin Sirbaugh	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1602 Olive St. Balto. Md. 21230		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Catonsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shane A. Savage	22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic adenocarcinoma of the colon	6 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard B. Williams, MD

29c. LICENSE NUMBER: D18807

29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard B. Williams MD, 3001 S. Hanover St., Baltimore 21230

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMN-18 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23491

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred L. Schauer			2. DATE OF DEATH: Month 9, Day 26, Year 89	3. TIME OF DEATH: 10 P M
4. SOCIAL SECURITY NUMBER: 217-80-9162	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): June 23 1911	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury	9c. COUNTY OF DEATH: Wicomico		

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: PARKVILLE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3127 ACTON ROAD	10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S.F.+G.	16b. KIND OF BUSINESS/INDUSTRY: SECRETARY
17. FATHER'S NAME (First, Middle, Last): ALBERT BOND		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ELLEN WILMER	
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND MEMORIAL PK.	20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Cardiomyopathy
Congestive Heart Failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: D34768	29d. DATE SIGNED (Month, Day, Year): 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 560 RIVERSIDE DRIVE SALISBURY, MD. JEFFERY WIELAND		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23492
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles T. Shallcross		2. DATE OF DEATH: MONTH 8 DAY 26 YEAR 89	3. TIME OF DEATH: 0515 A M
4. SOCIAL SECURITY NUMBER: 139-30-7931	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/19/10 — 8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis	9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT			
10a. STATE: New Jersey	10b. COUNTY: Union	10c. CITY, TOWN OR LOCATION: Elizabeth	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 117 Princeton Road	10f. ZIP CODE: 07208	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W. W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): College +	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director of Physical Welfare	16b. KIND OF BUSINESS/INDUSTRY: Elizabeth Board of Education	
17. FATHER'S NAME (First, Middle, Last): John Shallsross	18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret McQuaide		
19a. INFORMANT'S NAME (Type/Print): Kathleen Shallcross	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 Princeton Road Elizabeth, N.J. 07208		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rosehill Cemetery	20c. LOCATION — City or Town, State: Linden, New Jersey	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph J. Kellner	22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, INC. 8728 Liberty Road Randallstown, MD 21133		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis / Renal Failure	30d
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Ruptured Abdominal Aortic Aneurysm	30d
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [/] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] — 29c. LICENSE NUMBER: D25178 — 29d. DATE SIGNED (Month, Day, Year): 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT MOORE ANNAPOLIS MD.

31. DATE FILED (Month, Day, Year): AUG 29 1989 — 32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23493

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Kathryn	Renee	SHAUGHNESSY	August 23, 1989	3:05 P.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-70-3836	1 ☐ M 2 ☒ F	34 YRS.			4-4-1955	MARYLAND

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
FRANKLIN SQUARE HOSPITAL	ROSSVILLE	Baltimore, Co.

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	BALTIMORE	DUNDALK	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2013 DINEEN DRIVE	21222	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12TH GRADE	N/A	HOUSEWIFE	OWN HOME

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
GEORGE P. BUTCHER, III	MARY CATHERINE SCHUNCKE

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOHN MICHAEL SHAUGHNESSY	2013 DINEEN DRIVE BALTIMORE, MARYLAND 21222

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	SACRED HEART OF JESUS 8-26-89	BALTIMORE, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Thomas V. Fiala	DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Increased Intracranial Pressure.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Colloid Cyst of 111 Ventricle.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
David M Cook MD	D12535	8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David M. Cook 9000 Franklin Square Dr. Baltimore, MD. 21237.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Kinnard

DHMH-18 Rev 1/89

89 23494

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Melvin E. Stern				2. DATE OF DEATH: MONTH 8 DAY 25 YEAR 89	3. TIME OF DEATH: 0115 PM
4. SOCIAL SECURITY NUMBER: 217 05 5205	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2/9/18	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 2311 Hamilton Avenue		10f. ZIP CODE: 21214	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Purchasing Agent	16b. KIND OF BUSINESS/INDUSTRY: R.S.Stern Inc.	
17. FATHER'S NAME (First, Middle, Last): David Stern		18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Byrne	
19a. INFORMANT'S NAME (Type/Print): Doris L. Schell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2311 Hamilton Avenue Baltimore, Md. 21214	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ james F. Gladden James F. Gladden		22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck Inc. 5305 Harford Rd.21214	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. hypotension

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. sepsis, GI bleed

DUE TO (OR AS A CONSEQUENCE OF):

c. severe pulmonary hypertension

DUE TO (OR AS A CONSEQUENCE OF):

d. severe COPD, r/o CHF

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T Weissbein, MD	29c. LICENSE NUMBER: Medical Resident	29d. DATE SIGNED (Month, Day, Year) ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T. Weissbein, MD 3300 Wyman Park Dr., Baltimore, MD 21211		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23495

4

1. DECEDENT'S NAME (First, Middle, Last): Jack Turteltaub

2. DATE OF DEATH (Month, Day, Year): 8 27 1989

3. TIME OF DEATH: 7:20 AM

4. SOCIAL SECURITY NUMBER: 114 10 3622 A

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 88 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8/23/1901

8. BIRTHPLACE (State or Foreign Country): Austria

9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Rockville

10d. INSIDE CITY LIMITS?: [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 6121 Montrose Road

10f. ZIP CODE: 20852

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 years
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk

16b. KIND OF BUSINESS/INDUSTRY: Store

17. FATHER'S NAME (First, Middle, Last): Aaron Turteltaub

18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Henner

19a. INFORMANT'S NAME (Type/Print): Robert Taub

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1602 Parham Road, Silver Spring, Maryland 20903

20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Judean Memorial Gardens

20c. LOCATION — City or Town, State: Olney, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald M. Stein

22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D.C.

TO BE COMPLETED BY FUNERAL DIRECTOR — RELEASED BY ME

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Aspiration pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?: 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?: 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?: 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK?: 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D23170

29d. DATE SIGNED (Month, Day, Year): ▶ 08/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Alan S. Chanales, M. D., 8218 Wisconsin Avenue, Bethesda, Maryland 20814

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 23496

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hong How Tsao				2. DATE OF DEATH (Month, Day, Year): 8-23-89	3. TIME OF DEATH: 4:36PM M
4. SOCIAL SECURITY NUMBER: 216-52-9758	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 13, 1898	8. BIRTHPLACE (State or Foreign Country): China
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4504 Schenley Rd.		10f. ZIP CODE: 21210	10g. CITIZEN OF WHAT COUNTRY?: China

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Oriental

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Chin Tai Yu		18. MOTHER'S NAME (First, Middle, Maiden Surname): Tavn To Kowng	
19a. INFORMANT'S NAME (Type/Print): Chak Wing Tsao		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem.Gdns.8/28/89	20c. LOCATION — City or Town, State: Timonium, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO INQUIRY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Gubs Davidson-Randall

DHMH-16 Rev 1/89

89 23497

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician ... Parts 1, 2, 3 should

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ormond H. Wright Sr.				2. DATE OF DEATH (Month, Day, Year): 08-24-1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-03-3982	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 05-08-1911	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Meridian Caton Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: =====

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: ====	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 605 Washburn Avenue		10f. ZIP CODE: 21225	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Locksmith	16b. KIND OF BUSINESS/INDUSTRY: Maryland Ship Building	
17. FATHER'S NAME (First, Middle, Last): Hugh Wright		18. MOTHER'S NAME (First, Middle, Maiden Surname):	
19a. INFORMANT'S NAME (Type/Print): Rita Wright	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 605 Washburn Avenue Baltimore, Maryland 21225		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery	20c. LOCATION — City or Town, State: Brooklyn Park, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George J. Gonce	22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma Small Cell, Left Lung	8 Months
DUE TO (OR AS A CONSEQUENCE OF):	b. Brain Metastasis	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Coronary Artery Disease	yr
DUE TO (OR AS A CONSEQUENCE OF):	d. Arteriosclerotic Cardiovascular Disease	yr

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Rolando V. Goco, M.D		29c. LICENSE NUMBER: D0 1860	29d. DATE SIGNED (Month, Day, Year): 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rolando V. Goco, MD 707 E. Fort Ave, Bmt. MD 21230

31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23498

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Madeline Wojcik			2. DATE OF DEATH: MONTH 8 DAY 28 YEAR 89	3. TIME OF DEATH: 5:06 A M
4. SOCIAL SECURITY NUMBER: 170-20-3442	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-18-26	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: ======
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8492 Jenkins Road		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 10 th Grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Michael Fedinick		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Hazebroda		
19a. INFORMANT'S NAME (Type/Print): Walter Wojcik		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8492 Jenkins Road Pasadena, Maryland 21122		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery		20c. LOCATION — City or Town, State: Brooklyn Park, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Richard Gonce		22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hwy. Balto., Md. 21225		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Cardiogenic Shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Recent NON-Q Myocardial Infarct

DUE TO (OR AS A CONSEQUENCE OF):

c. pulmonary Edema

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Harbor Hosp, B-G. Park MD 3001 S. Hanover St		
31. DATE FILED (Month, Day, Year): AUG 29 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23499
REG. NO.

15

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sadie Ruth Weinstein			2. DATE OF DEATH (Month, Day, Year): August 27 1989	3. TIME OF DEATH: 10:20 P.M
4. SOCIAL SECURITY NUMBER: 577 76 2964	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): October 15, 1900	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sylvan Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2700 Barker Street		10f. ZIP CODE: 20910		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Simon Berman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophie Sober		
19a. INFORMANT'S NAME (Type/Print): Allen J. Weinstein		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800 Yellowstone Place, Bowie, Maryland 20715		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): B'nai Israel Congregation Cemetery	20c. LOCATION — City or Town, State: Oxon Hill, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein	22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. As a consequence of Heart Disease	5 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Myron L Lenkin MD

29c. LICENSE NUMBER: D06674

29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Myron L. Lenkin, M. D.,2309 Shorefield Road, Wheaton, Maryland 20902

31. DATE FILED (Month, Day, Year): AUG 29 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

9 240 05 33 JHH

WORTHY, JEANETTE 89 23500

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Janette Worthy
2. DATE OF DEATH: MONTH 08 DAY 26 YEAR 89
3. TIME OF DEATH: 3:56 am M
4. SOCIAL SECURITY NUMBER: 245-38-8898
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 62 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/25/27
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 426 E. Federal Street
10f. ZIP CODE: 21202
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farming
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Robert Worthy
18. MOTHER'S NAME (First, Middle, Maiden Surname): Collena Lawrence

19a. INFORMANT'S NAME (Type/Print): Octavia Robinson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 426 E. Federal Street Balto. 21202

20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify):
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery
20c. LOCATION — City or Town, State: Balto. Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gloria Adams Jones
22. NAME AND ADDRESS OF FACILITY: MARSHALL D. JONES, JR. F.H. PA 4101 Edmondson Ave. Balto. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hypotension	48 hrs.
DUE TO (OR AS A CONSEQUENCE OF): b.	Seizures - status epilepticus	3d
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Metastatic Cancer of unknown primary	16mo
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Denise S. Bason
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 9/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Denise S. Bason JHH Baltimore, MD 21205
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23501
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edith EDITH B. WILE
2. DATE OF DEATH: MONTH 8 DAY 24 YEAR 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-07-8965
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): MAR.16,1918
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 10 PATAPSCO RD.
9b. CITY, TOWN OR LOCATION OF DEATH: LINTHICUM HEIGHTS
9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: LINTHICUM HEIGHTS
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10 PATAPSCO RD.
10f. ZIP CODE: 21090
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: NO
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5 +): 6 YEARS
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHEMIST
16b. KIND OF BUSINESS/INDUSTRY: AIR CONTROL
17. FATNER'S NAME (First, Middle, Last): JOSEPH W. BOYD
18. MOTNER'S NAME (First, Middle, Maiden Surname): MARY W. McWILLIS
19a. INFORMANT'S NAME (Type/Print): CARL E. WILE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 PATAPSCO RD. LINTHICUM HEIGHTS, MD. 21090
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY INC.
20c. LOCATION — City or Town, State: CATONSVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S M Lowmer
22. NAME AND ADDRESS OF FACILITY: McCULLY FUNERAL HOME 237 PATAPSCO AVE. BALTO. MD. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the Burial Transit Permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or reepiratory arreat, ahock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Adenocarcinoma of liver
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Ischemic Heart disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D-34095
29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Jorge Acevedo M.D. 200 Hospital Drive Suite 20, Glen Burnie Md.
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

89 23502

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEO E. ZENTGRAF			2. DATE OF DEATH (Month, Day, Year): 08 19 89	3. TIME OF DEATH: 9:00 A M
4. SOCIAL SECURITY NUMBER: 212-09-8903	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-27-1909	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTO. CO.	10c. CITY, TOWN OR LOCATION: PARKVILLE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO	
10e. STREET AND NUMBER: 2916 WILLOUGHBY RD.		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — ~~American Indian~~, ~~Black~~, White, ~~etc~~ Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BANK CLERK	16b. KIND OF BUSINESS/INDUSTRY: BANKING		
17. FATHER'S NAME (First, Middle, Last): EDWARD ZENTGRAF		18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA KECKEN		
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE			
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEM.	20c. LOCATION — City or Town, State: PARKVILLE, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey L. Gair	22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Coronary artery disease.

DUE TO (OR AS A CONSEQUENCE OF):

c. Generalized arteriosclerotic disease.

DUE TO (OR AS A CONSEQUENCE OF):

d. Severe ischemia both feet.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jose T. Valle Jr. M.D.	D 158 24	▶ 8/19/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Gina Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the [illegible] permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 23503

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)		3. TIME OF DEATH
WILLIAM	LEE	BROUGHMAN, SR.	8	26 89	11:34 PM
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
232-46-1719	1 [X] M 2 [ ] F	56 YRS.			4-16-1933	WEST VIRGINIA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Francis Scott Key Medical Center	Baltimore	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND		BALTIMORE CITY	1 [X] YES NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1345 BROENING HIGHWAY	21224	U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: KOREA	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
11 TH GRADE	N/A	MECHANIC	CONTINENTAL CAN COMPANY

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
JOSEPH P. BROUGHMAN	VIRGIE PAYNE

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LOUISE M. BROUGHMAN	1345 BROENING HIGHWAY BALTIMORE, MD 21224

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
	GARDENS OF FAITH CEM. 8-30-89	BALTIMORE, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
[signature]	DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardidovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
	Inquiry	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Ann M. Dixon, MD. 111 Penn Street Baltimore, Md. 21201	
31. DATE FILED (Month, Day, Year) AUG 30 1989	32. REGISTRAR'S SIGNATURE [signature] Julia Davidson-Randall

OHMH-16 Rev 1/89

89 23504

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MABEL MADLYN BLAND			2. DATE OF DEATH (Month, Day, Year): Aug. 27, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 217-20-7737	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 16, 1923	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2318 Braddish Ave.		10f. ZIP CODE: 21216	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electronic Worker	16b. KIND OF BUSINESS/INDUSTRY: Westinghouse Corporation	
17. FATHER'S NAME (First, Middle, Last): Burrell Bell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Crafton	
19a. INFORMANT'S NAME (Type/Print): Thomas H. Bland		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2318 Braddisg Ave. Baltimore, Maryland 21216	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cemetery	20c. LOCATION — City or Town, State: Baltimore, County MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Autumne Lowry		22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Pulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Hypercholesterolemia

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jerald Indel	29c. LICENSE NUMBER: 60021	29d. DATE SIGNED (Month, Day, Year): 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5601 Loch Raven Blvd		
31. DATE FILED (Month, Day, Year): AUG 30 1989 8/30/89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23505
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Norman B. Belbot
2. DATE OF DEATH — MONTH: 8 DAY: 29 YEAR: 89
3. TIME OF DEATH: 7:34 PM
4. SOCIAL SECURITY NUMBER: 219-18-1194
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-21-26
8. BIRTHPLACE (State or Foreign Country): Balto. MD.
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4511 Fullerton Avenue
10f. ZIP CODE: 21236
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Insurance Agent
16b. KIND OF BUSINESS/INDUSTRY: Freestate Insurance
17. FATHER'S NAME (First, Middle, Last): Felix Belbot
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Stryjewski
19a. INFORMANT'S NAME (Type/Print): Anna E. Belbot
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4511 Fullerton Avenue- Baltimore,Md.-21236
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery
20c. LOCATION — City or Town, State: Baltimore,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph B. Beil Jr.
22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 BElair Road,Baltimore,Md.-21206

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sudden cused intreatable ventr. Fibrill.	1 hr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b. S/P MI	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. S/P PE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: same as p. I

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C. Fritz MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Corinna Fritz, 201 E. Univ. Pkway, Baltimore MD 21218
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23506

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie Brandis Bernhardt		2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 227-01-6197	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 30, 1915
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): 3206 Ascot Lane	9b. CITY, TOWN OR LOCATION OF DEATH: Fallston, Maryland	9c. COUNTY OF DEATH: Harford	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Fallston	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3206 Ascot Lane	10f. ZIP CODE: 21047	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education	
17. FATHER'S NAME (First, Middle, Last): Ernest Linwood Brandis	18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Todd		
19a. INFORMANT'S NAME (Type/Print): Mr. Otto P. Bernhardt, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3206 Ascot Lane, Fallston, Md. 21047		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bryan W. Clary	22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, Md. 21093		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intestinal Obstruction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cancer of the Ovary	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: #D1778	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 6701 N. Charles St. Towson, Md. 21204		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23507

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified ...

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis Joseph Benesch			2. DATE OF DEATH: Month 08 Day 27 Year 89	3. TIME OF DEATH: 6:58 PM
4. SOCIAL SECURITY NUMBER: 213-10-4560	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 8-25-12	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Fallston MD		9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Fallston	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rear of 1711 Laurel Brook Rd.		10f. ZIP CODE: 21047	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed	16b. KIND OF BUSINESS/INDUSTRY: Laurel Brook Nurs. Home	
17. FATHER'S NAME (First, Middle, Last): Ignatius M. Benesch		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Marshat	
19a. INFORMANT'S NAME (Type/Print): Barbara M. Benesch		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rear of 1711 Laurel Brook Rd. 21047	
20a. METNOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Fissehn Funeral Home		22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD with carotid

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. atherosclerosis

DUE TO (OR AS A CONSEQUENCE OF): d. S/P Aorto bifemoral Bypass

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Perfecto V. Valarao	29c. LICENSE NUMBER: D16-389	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PERFECTO VALARAO, M.D. 1716 HARFORD RD FALLSTON MD 21047		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

6 +1

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23508 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 5 may be obtained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donna Marie Blevins				2. DATE OF DEATH (Month, Day, Year): 8 27 89	3. TIME OF DEATH: 5:00 A M
4. SOCIAL SECURITY NUMBER: 207-26-4326	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)		7. DATE OF BIRTH (Month, Day, Year): 3 15 18	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 3409 Conowingo Rd		9b. CITY, TOWN OR LOCATION OF DEATH: Street MD		9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Harford	Street	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
3409 Conowingo Road	21154	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
3		Homemaker	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Weldon E. Parks	Jincy R. Hash

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frances R. Lehr	3929 Conowingo Rd., Darlington, MD.,21034

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Darlington Cemetery	Darlington, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John D. Tillett	Harkins F.H.Inc., 600 Main St., Delta, PA

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypotension & Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Richard J. Colfer MD Dep. Medical Examiner	DO 1194	▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
RICHARD J. COLFER, MD	2013 Trappe Church Rd Darlington, MD 21034	AUG 30 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23509

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified and

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Catherine H. Bailey			Aug. 24 1989	6:30p M
4. SOCIAL SECURITY NUMBER	**5. SEX**	**6. AGE (In yrs. last birthday)**	**IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.**	**7. DATE OF BIRTH (Month, Day, Year)**	**8. BIRTHPLACE (State or Foreign Country)**
215-52-0015	1 ☐ M 2 ☒ F	69 YRS.		Feb. 4 1920	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
564 Welbrook Road	Baltimore	Baltimore

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	BAltimore	Essex	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
564 Welbrook Road	21221	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
7th		Housewife	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Howard V. Johnson	Bessie C. Kimmell

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Katherine Hare	564 Welbrook Road Baltimore Md. 21221

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Oak LAwn Cemetery	Baltimore Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Connelly Funeral Home	Connelly Funeral Home 300MaceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COPD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cor Pulmonale.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Nadeem Quamar		▶ 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
Nadeem Quamar	9000 Franklin Square Drive	21237

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	[illegible]

DHMH-18 Rev 1/89

89 23510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) MARGUERITE THERESA BLANSFIELD MARGUERITE BLANSFIELD			2. DATE OF DEATH MONTH 08 DAY 26 YEAR 89	3. TIME OF DEATH 10:46 AM
4. SOCIAL SECURITY NUMBER 215-24-9317	5. SEX 1 ☐ M 2 ☒ F	6. AGE (If under 1 year/24 hrs.) 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 6-29-00	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hosp			9b. CITY, TOWN OR LOCATION OF DEATH Towson	9c. COUNTY OF DEATH Baltimore
RESIDENCE OF DECEDENT				
10a. STATE Md.	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION ~~MXXX~~ Baltimore		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 911 Breezewick Cr.		10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6 College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY N/A
17. FATHER'S NAME (First, Middle, Last) Martin Patrick Foley			18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Louise	
19a. INFORMANT'S NAME (Type/Print) Marguerite B. Beigel			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Breezewick Cir. Towson, Md. 21204	
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley		20c. LOCATION — City or Town, State Lutherville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Dennis S. Xenakis			22. NAME AND ADDRESS OF FACILITY Mitchell- Wiedefeld Home 6500 York Road 21212	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER D33215
29d. DATE SIGNED (Month, Day, Year) ▶ 08/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year) AUG 30 1989
32. REGISTRAR'S SIGNATURE Julia Davidson-Pendell

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23511
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elmer B. Cogar
2. DATE OF DEATH (Month, Day, Year): Aug. 25, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 232-24-4046
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 6-9-1918
8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1950 Snyder Avenue
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MILL WORKER
16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL CORP.
17. FATHER'S NAME (First, Middle, Last): FRANK COGAR
18. MOTHER'S NAME (First, Middle, Maiden Surname): CORA NOT KNOWN
19a. INFORMANT'S NAME (Type/Print): ANNA M. COGAR
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1950 SNYDER AVENUE BALTIMORE, MARYLAND 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM. 8-29-89
20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott Ruck
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Possible Acute Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): b. DSWD.

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [/] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) Home
27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? 1 [ ] YES 2 [/] NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donato A. Vargas M.D.
29c. LICENSE NUMBER: 21748
29d. DATE SIGNED (Month, Day, Year): 8-25-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donato A. Vargas JR 4706 Harford Rd, Balto, MD 21214
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23512

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): REGINA A. CORONEL		2. DATE OF DEATH: MONTH 8 DAY 26 YEAR 89	3. TIME OF DEATH: 3:36 A M
4. SOCIAL SECURITY NUMBER: 216-76-8389	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 30 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/1/1959
8. BIRTHPLACE (State or Foreign Country): Phillippines			
9a. FACILITY NAME (If not institution, give street and number): Northbound J.F.X.	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Lutherville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1509 Melton Rd.	10f. ZIP CODE: 21093	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Oriental

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Physician Assistant
16b. KIND OF BUSINESS/INDUSTRY: Medical		
17. FATHER'S NAME (First, Middle, Last): Danilo Coronel	18. MOTHER'S NAME (First, Middle, Maiden Surname): Doris Aguilar	
19a. INFORMANT'S NAME (Type/Print): Danilo Coronel	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley 8/30/89	20c. LOCATION — City or Town, State: Timonium, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald E. Schafer Jr.	22. NAME AND ADDRESS OF FACILITY: 1050 York Rd, 21204 Ruck Towson Funeral Home, Inc.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cervical trauma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) scene	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-26-89	28b. TIME OF INJURY: 3:20A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: Driver of auto that lost control			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): highway	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N-bound J.F.X., S. of Northern Parkway exit		

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ann M. Dixon, M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn Street Baltimore, MD. 21201		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23513
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE E. DAY			2. DATE OF DEATH: MONTH 8 DAY 24 YEAR 1989	3. TIME OF DEATH: 10:25 P M
4. SOCIAL SECURITY NUMBER: 217-40-2821	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 10, 1942	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2908 Old Court Road		10f. ZIP CODE: 21208		10g. CITIZEN OF WHAT COUNTRY? U. S. A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): College 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed		16b. KIND OF BUSINESS/INDUSTRY: Salon Operator/Owner
17. FATHER'S NAME (First, Middle, Last): Jesse Day		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lorraine Brown		
19a. INFORMANT'S NAME (Type/Print): Ernestine M. Day		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2908 Old Court Road Baltimore, Maryland 21208		
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery	20c. LOCATION — City or Town, State: Baltimore County, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest T Nutter	22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple gunshot wounds	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-24-89	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2908 Old Court Rd., Pikesville

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	OCME	▶ 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 23514

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VICTOR PAUL De LIBERA		2. DATE OF DEATH (Month, Day, Year): AUGUST 27, 1989	3. TIME OF DEATH: 10 15 A M
4. SOCIAL SECURITY NUMBER: 217-24-3392	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-24-1929
8. BIRTHPLACE (State or Foreign Country): OHIO			
9a. FACILITY NAME (If not institution, give street and number): 3115 DUNGLOW ROAD	9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: DUNDALK	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3115 DUNGLOW ROAD	10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 TH GRADE; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STORE OWNER	16b. KIND OF BUSINESS/INDUSTRY: DUNDALK HARDWARE	
17. FATHER'S NAME (First, Middle, Last): FRANK De LIBERA	18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA CASAGRANDE		
19a. INFORMANT'S NAME (Type/Print): FLORENCE De LIBERA	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3115 DUNGLOW ROAD BALTIMORE, MARYLAND 21222		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [XX] Other (Specify) ENTOMBMENT	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEM. 8-30-89	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Geo P. Gardner	22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory arrest.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): a. Metastatic Adenocarcinoma of lung	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Theo Patterson, M.D.	29c. LICENSE NUMBER: P. 7536	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THEO. C PATTERSON, M.D.		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23515

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Elizabeth Dezurn		Aug 22, 1989	M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-76-5653	1 ☐ M 2 ☒ F	67 YRS.			April 15, 1922	North Carolina

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
4207 Pimlico Road	Baltimore	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland		Baltimore	☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4207 Pimlico Road	21215	U. S. A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
8th Grade		Homemaker	Domestic

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Jack Saunders	Laura Williams

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Hamlet	3017 Wylie Ave. Baltimore, Maryland 21215

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶	Nutter Funeral Homes Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CEREBROVASCULAR ACCIDENT	~ MINUTES
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HYPERTENSION	54 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC Renal Failure

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Paul C Sapir MD	DC D10670	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
D. SAPIR 9E. CHASE ST 21202

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23516

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Earle Maude DREWRY				2. DATE OF DEATH (Month, Day, Year): August 26, 1989	3. TIME OF DEATH: 7:50 pM
4. SOCIAL SECURITY NUMBER: 213-03-6216	5. SEX: 1 ☐ M 2 XX F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-20-1906	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: ROSSVILLE		9c. COUNTY OF DEATH: Baltimore County
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: DUNDALK			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 1301 WILLOW ROAD		10f. ZIP CODE: 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NOT KNOWN; College (1-4 or 8 +): NOT KNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER		16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): CHARLES ROBERTS			18. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE BOWLES		
19a. INFORMANT'S NAME (Type/Print): BERNARD ROBERTS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1301 WILLOW ROAD BALTIMORE, MARYLAND 21222			
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 8-30-89		20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott DuAcre		22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Azotemia.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Mental Obtundation.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
TA Stephens	N/A	8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Theodore Stephens, M.D. 9000 Franklin Square Dr, Baltimore 21237.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Jane Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23517
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martha DILLON			2. DATE OF DEATH (Month, Day, Year): August 26, 1989	3. TIME OF DEATH: 9:25 p.m.
4. SOCIAL SECURITY NUMBER: 216-24-8130	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 10, 1929	8. BIRTHPLACE (State or Foreign Country): WestVirginia
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Dundalk	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8218 Watersedge Road		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Anthony F. Suder	18. MOTHER'S NAME (First, Middle, Maiden Surname): Tecla Shotgass
19a. INFORMANT'S NAME (Type/Print): John P. Dillon	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8218 Watersedge Road BAltimore MAryland 21222

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Cemetery	20c. LOCATION — City or Town, State: BAlto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ T Paul Connelly Funeral Home	300 MAeR AvR	22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome of Dundalk 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: N/A	29d. DATE SIGNED (Month, Day, Year) ▶ 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Theodore Stephens, M.D. 9000 Franklin Square Dr. Baltimore 21237

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23518

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY DYER / DOROTHY PACY DYER				2. DATE OF DEATH (Month, Day, Year): AUGUST 26, 1989	3. TIME OF DEATH: 3:45 A M
4. SOCIAL SECURITY NUMBER: 216-12-3314	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-17-17	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1007 Bellemore Rd.		10f. ZIP CODE: 21210		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		15b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): Walter D. Pacy		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Rattman			
19a. INFORMANT'S NAME (Type/Print): Robert H. Dyer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1007 Bellemore Rd. Balto. Md. 21210			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount		20c. LOCATION — City or Town, State: Balto. City. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis S. Xenakis		22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road 21212			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Renal failure	1 wk
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Ovarian cancer	3 YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert C. MD

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) ▶ 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): AUG 30 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23519

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital ... Page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WOODROW, EDWARDS			2. DATE OF DEATH (Month, Day, Year): 8 / 25 / 89	3. TIME OF DEATH: 10:10 M
4. SOCIAL SECURITY NUMBER: 249-22-1885	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 12, 1920	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6422 Craigmont Road		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter	16b. KIND OF BUSINESS/INDUSTRY: Carpentr

17. FATHER'S NAME (First, Middle, Last): Elliott Edwards	18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Nicholson
19a. INFORMANT'S NAME (Type/Print): Delores Edwards	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6422 Craigmont Road Baltimore, Maryland 21229

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	20c. LOCATION — City or Town, State: Baltimore County, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon R Bailey	22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure ; Hypotension

DUE TO (OR AS A CONSEQUENCE OF): Pulmonary Embolism

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure
Possible aspiration pneumonitis
Seizure disorder; Multiple CVA -

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Geetha Raja MD Attending Physician	29c. LICENSE NUMBER: D27541	29d. DATE SIGNED (Month, Day, Year) ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEETHA RAJA M.D 3913 HOLLINS FERRY RD BALTIMORE MD-21227

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23520

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) ROSARIO J. FAVA / ROSARIO FAVA			2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89	3. TIME OF DEATH 7:30 A M
4. SOCIAL SECURITY NUMBER 213-03-0695	5. SEX 1 X M 2 ☐ F	6. AGE (In yrs. last birthday) 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year) 10-31-13	8. BIRTHPLACE (State or Foreign Country) MD
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH Towson, MD		9c. COUNTY OF DEATH Baltimore County

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER 15 W. Lake Ave.		10f. ZIP CODE 21210	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 9 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Restauranteur	16b. KIND OF BUSINESS/INDUSTRY Restaurant	
17. FATHER'S NAME (First, Middle, Last) Frank Fava		18. MOTHER'S NAME (First, Middle, Maiden Surname) Constanza D'Antoni	
19a. INFORMANT'S NAME (Type/Print) Angeline P. Fava	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10		
20a. METHOD OF DISPOSITION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem.Gdns.8/30/89	20c. LOCATION — City or Town, State Timonium, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Ronald C. Schuyler Jr.	22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence X ☐ Other (Specify) Hospice

27. MANNER OF DEATH 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER C Alexander MD	29c. LICENSE NUMBER D27087	29d. DATE SIGNED (Month, Day, Year) ▶ 8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

31. DATE FILED (Month, Day, Year) AUG 30 1989	32. REGISTRAR'S SIGNATURE Gisha Davidson-Kandell

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23521 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Gladney, Sr.			2. DATE OF DEATH (Month, Day, Year): Aug. 25, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 249-18-1955	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan 28, 1924	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1771 Darley Ave.		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY? U. S. A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fork Lift Operator	16b. KIND OF BUSINESS/INDUSTRY: Refinery Company	
17. FATHER'S NAME (First, Middle, Last): John Gladney		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Young	
19a. INFORMANT'S NAME (Type/Print): Mamie Gladney		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1771 Darley Ave. Baltimore, Maryland 21213	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Ceme.	20c. LOCATION — City or Town, State: Baltimore Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Larry L. Rollen		22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. atherosclerotic Vessel disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. hypertension, hypercholesterolemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. insulin dependent diabetes	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Florence Houn MD	29c. LICENSE NUMBER: D34756	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): 2323 Orleans St Baltimore MD 21224		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23522

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
JERRY	S.	GAINEY ~~GAYNEY~~	8 / 26 / 89	4:33 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-34-8605	1 [X] M 2 [ ] F	50 YRS.			Jan 23 1939	North Carolina

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
2906 Miles Avenue	Baltimore	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.		Baltimore	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2906 Miles Ave.	21211	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 8+)		
7th		Painter	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sandy Gainey	Idell Ellis

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Gainey	5023 E. Oliver Street Balto, Md. 21205

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metro Crematory Inc.	Balto. Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Connelly Funeral Home	Connelly Funeral Home 300MaceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO
Inspection	

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita Korell	OCME	8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
Margarita A. Korell, M.D.	111 Penn Street	Baltimore, Md. 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23523 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy F. Howard
2. DATE OF DEATH (Month, Day, Year): 8/25/89
3. TIME OF DEATH: 4:55 A M
4. SOCIAL SECURITY NUMBER: 220-20-6505
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/29/05
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): FSK mc
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1300 S. Ellwood
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): College 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: Balto., Co. Public Schools

17. FATHER'S NAME (First, Middle, Last): JACOB Howard
18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Matthews

19a. INFORMANT'S NAME (Type/Print): Doris Wallace
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3204 Auchentoroly Lane Baltimore, Maryland 21217

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Auburn Cemetery
20c. LOCATION — City or Town, State: Howard Co., Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joan L. Collins
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest - ? Etiology &	3½ days
DUE TO (OR AS A CONSEQUENCE OF):	b. (possibly 2° Pulmonary embolus)	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF):	c. Alzheimer's Disease	
	d. Sedentary lifestyle	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
25. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R Dimmana MD
29c. LICENSE NUMBER: D38353
29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID ALLEN MD FRANCIS SCOTT KEY MEDICAL CTR BALT MD 21224.
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23524

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Irving F. Harris Jr.

2. DATE OF DEATH Month: 8 Day: 22 Year: 89

3. TIME OF DEATH: 11 50 PM M

4. SOCIAL SECURITY NUMBER: 578-34-5234

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 59 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 12-29-29

8. BIRTHPLACE (State or Foreign Country): Wash D.C.

9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Silver Spring

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER: 802 Hillsboro Dr

10f. ZIP CODE: 20902

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): College-Masters

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Teacher

16b. KIND OF BUSINESS/INDUSTRY: Gov.

17. FATHER'S NAME (First, Middle, Last): Irving Frank Harris, Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline N. Williams

19a. INFORMANT'S NAME (Type/Print): Mozella T. Harris-wife

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Hillsboro Drive-Silver Spring, Md.

20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Cemetery

20c. LOCATION — City or Town, State: Rockville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Stewart III

22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home, 4001 Benning Road, N.E.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hepatic Insufficiency	Days
DUE TO (OR AS A CONSEQUENCE OF): b.	Adeno carcinoma Pancreas	18 mo
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edgar H. Levin

29c. LICENSE NUMBER: D10690

29d. DATE SIGNED (Month, Day, Year): 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDGAR H. LEVIN M

31. DATE FILED (Month, Day, Year): AUG 30 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23525

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NELLIE ERNESTINE Hudson		2. DATE OF DEATH (Month, Day, Year): August 28, 1989	3. TIME OF DEATH: 2:35 AM M
4. SOCIAL SECURITY NUMBER: 218-16-6050	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08/02/17
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury	9c. COUNTY OF DEATH: Wicomico	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Salisbury	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1305 Middleneck Drive.	10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress	15b. KIND OF BUSINESS/INDUSTRY: Restaurant	
17. FATHER'S NAME (First, Middle, Last): Jake Workman	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Turner		
19a. INFORMANT'S NAME (Type/Print): Charles Joseph Hudson,Sr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1305 Middleneck Dr. Salisbury, MD 21801		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wicomico Memorial Park	20c. LOCATION — City or Town, State: Salisbury, MD 21801	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. Fred Burbage	22. NAME AND ADDRESS OF FACILITY: BURBAGE FUNERAL HOME 108 Williams St. Berlin, MD21811		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Refractory Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Donald M. Woods MD	W3311	8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD M. WOODS MD PHMC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julie Davidson-Randall

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23526

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES HILL			2. DATE OF DEATH: MONTH 08 DAY 22 YEAR 89	3. TIME OF DEATH: 1245 AM M
4. SOCIAL SECURITY NUMBER: 214-05-1947	5. SEX: 1 [#] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7/10/07	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Pasadena		10d. INSIDE CITY LIMITS? 1 [#] YES 2 [ ] NO
10e. STREET AND NUMBER: 8134 Hog Neck Road		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [#] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [#] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): James Wallace		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Hill		
19a. INFORMANT'S NAME (Type/Print): Katie Hill		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8134 Hog Neck Rd. Pasadena, Md. 21122		
20a. METHOD OF DISPOSITION: 1 [#] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion CH. Cemetery		20c. LOCATION — City or Town, State: Magothy, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Carl A Estep		22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hemoptysis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ca of the lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pulmonary Fibrosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. ASHD with CHF	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cachexia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Benito Martinez MD	D4809	▶ 8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BENITO MARTINEZ, M.D. 2932-A MOUNTAIN ROAD PASADENA, MARYLAND 21122

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23527
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Stanley H. Kampes, Jr.			2. DATE OF DEATH (Month, Day, Year): 8-27-89	3. TIME OF DEATH: 5:10AM M
4. SOCIAL SECURITY NUMBER: 218-44-5338	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 43 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 31,1946	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace		9c. COUNTY OF DEATH: Harford County

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Aberdeen	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 738 Custis St.		10f. ZIP CODE: 21001	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: A	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouse man	16b. KIND OF BUSINESS/INDUSTRY: Montgomery Ward	
17. FATHER'S NAME (First, Middle, Last): Stanley H. Kampes Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel M. Smith	
19a. INFORMANT'S NAME (Type/Print): Mrs. Sharon L. Kampes		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 738 Custis St. Aberdeen, Md. 21001	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Belair Memorial Gardens	20c. LOCATION — City or Town, State: Bel Air, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn		22. NAME AND ADDRESS OF FACILITY: E.F.Lassahn Funeral Home 11750 Belair Rd.Kingsville,Md.21087	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 3 0 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23528

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Romaine Kelbaugh
2. DATE OF DEATH (Month, Day, Year): August 27, 1989
3. TIME OF DEATH: 12:30P M
4. SOCIAL SECURITY NUMBER: 213-26-4958
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 3, 1928
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1421 Shawan Road
9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville, Md
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Cockeysville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1421 Shawan Road
10f. ZIP CODE: 21030
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Homemaker
17. FATHER'S NAME (First, Middle, Last): Frank Edward Baker
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Luen Morris
19a. INFORMANT'S NAME (Type/Print): Miss Teresa L. Kelbaugh
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1421 Shawan Road, Cockeysville, Md. 21030
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Carmel Cemetery
20c. LOCATION — City or Town, State: Parkton, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bryan W. Clary — Bryan W. Clary
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, Md. 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: 2+ yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell
29c. LICENSE NUMBER: D-09383
29d. DATE SIGNED (Month, Day, Year): August 27, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell MD - 7501 York Rd Towson Md 21204
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Gwen Saulsbury

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23529

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Olga KIRKWOOD
2. DATE OF DEATH (Month, Day, Year): 8 28 1989
3. TIME OF DEATH: 7:11 A M
4. SOCIAL SECURITY NUMBER: 215-01-7664
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): Aug. 24 1907
8. BIRTHPLACE (State or Foreign Country): Austria
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Rossville
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Essex
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1000 Franklin Ave.
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: X
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Louis Gehl
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Kuhn
19a. INFORMANT'S NAME (Type/Print): Elda Gutcher
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 332 Ringold Valley Circle Cockeysville Md.
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery
20c. LOCATION — City or Town, State: Baltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MaceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Severe Chronic obstructive pulmonary disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):		
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gauhar MD
29c. LICENSE NUMBER: D18326
29d. DATE SIGNED (Month, Day, Year): 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Haeem Gauhar 5400 Old Court Road Randallstown, Maryland 21133
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23530

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Geni (Jenny) Lilian Milibak		2. DATE OF DEATH (Month, Day, Year): AUGUST 29 1989	3. TIME OF DEATH: 6:15 A M
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 38 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 19, 1950
8. BIRTHPLACE (State or Foreign Country): Ecuador			
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: N/A	10b. COUNTY: Ecuador	10c. CITY, TOWN OR LOCATION: Cuenca	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: Hno. Miguel 1384	10f. ZIP CODE: N/A	10g. CITIZEN OF WHAT COUNTRY?: Ecuador	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: Equadorian	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Carlos Velez	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lilia Alvear		
19a. INFORMANT'S NAME (Type/Print): Carlos J. Milibak	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Hno. Miguel 1384 Cuenca, Ecuador		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cuenca Cemetery 9-3-89	20c. LOCATION — City or Town, State: Cuenca, Ecuador	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather ▶ Roy H. Cather	22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NON-HODGKINS LYMPHOMA	6 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gregory Kalemkerian MD	29c. LICENSE NUMBER: D 38494	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGORY KALEMKERIAN, MD 600 N. WOLFE RD, BALTIMORE

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23531
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTHA MC CARTY				2. DATE OF DEATH (Month, Day, Year): AUGUST 29, 1989	3. TIME OF DEATH: 3;45 P.M
4. SOCIAL SECURITY NUMBER: 215-03-4197	5. SEX: 1 ~~M~~ 2 ~~F~~ X	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 19 1917	8. BIRTHPLACE (State or Foreign Country): Maryland
8a. FACILITY NAME (If not institution, give street and number): CHURCH CORPORATION HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: MD.	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2944 Cornwall Rd.		10f. ZIP CODE: 21222		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier		16b. KIND OF BUSINESS/INDUSTRY: Two Guys	
17. FATHER'S NAME (First, Middle, Last): Frederick Waire				18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine ==	
19a. INFORMANT'S NAME (Type/Print): Clinton McCarty		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2944 Cornwall Road Baltimore MAryland 21222			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery		20c. LOCATION — City or Town, State: Baltimore Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home		22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 21222			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the moda of dying, such aa cardiac or raapiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death: several weeks

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. encephalapathy
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly liet conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted eventa resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: respiratory failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Timothy J. Low, M.D.	MD D24034	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy J. Low, M.D. Church Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23532

10

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret A. McQuade					2. DATE OF DEATH (Month, Day, Year): August 26 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-44-3314	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 45 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 31 1943	8. BIRTHPLACE (State or Foreign Country): MAryland
9a. FACILITY NAME (If not institution, give street and number): 105 W. 39th Street Apt/903			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT						
10a. STATE: Md.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore City			10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO	
10e. STREET AND NUMBER: 105 W. 39th Street Apt/903		10f. ZIP CODE: 21210			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Rental Agent			16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Thomas H. Earley				18. MOTHER'S NAME (First, Middle, Maiden Surname): Marjorie E. Bass		
19a. INFORMANT'S NAME (Type/Print): Thomas Earley			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 840 Brunswick Road Apt.2B BAlto. Md. 21221			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Annunciation Cemetery			20c. LOCATION — City or Town, State: Shenendoah PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home			22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MaceAve. 21221			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intestinal Obstruction	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Cervical Cancer - advanced	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]		▶ 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 6701 N. Charles St. Balto, Md. 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	[signature]

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23533
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ETTA McCARTY				2. DATE OF DEATH (Month, Day, Year): AUGUST 24 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-84-7496	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 12, 1915	8. BIRTHPLACE (State or Foreign Country): Tennessee
9a. FACILITY NAME (If not institution, give street and number): 615 NORTH LUZERNE AVE. 21205			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: City	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 615 N. Luzerne Ave.		10f. ZIP CODE: 21205	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Christopher Brantley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Matilda Wyrick	
19a. INFORMANT'S NAME (Type/Print): Shelby Schwing		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Henry Ave. , Baltimore, Maryland 21236	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Prospect Hill Cemetery 8-28-89	20c. LOCATION — City or Town, State: Towson, Maryland 21204
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr.		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road , Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MyoCARdial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CARdiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: N. LeThanne, M.D.	29c. LICENSE NUMBER: D 27411	29d. DATE SIGNED (Month, Day, Year): ▶ 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. NARESH KHANNA

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-1S Rev 1/89

Item 10a,c,e,&f corrected G film 655 9/10/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23534
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ... be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSE M. MANFREDI			2. DATE OF DEATH (Month, Day, Year): 8-22-89	3. TIME OF DEATH: 5:00P M
4. SOCIAL SECURITY NUMBER: 053-18-5448	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-14-10
8. BIRTHPLACE (State or Foreign Country): New York				
9a. FACILITY NAME (If not institution, give street and number): Manor Care Ruxton		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: ~~Md.~~ New York	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: ~~Baltimore~~ Sound Beach	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: ~~5705 St. Albans Way~~ 21 Huntington Dr.	10f. ZIP CODE: ~~21212~~ 11789	10g. CITIZEN OF WHAT COUNTRY: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retail	16b. KIND OF BUSINESS/INDUSTRY: Grocer	
17. FATHER'S NAME (First, Middle, Last): Ralph Rubino		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary	
19a. INFORMANT'S NAME (Type/Print): Douglas Casimer F.H.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 523 Rt. 112 Port Jefferson N.Y.	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Sepulchre	20c. LOCATION — City or Town, State: Coram, New York
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis S. Xenakis		22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road 21212	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Months

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Stroke

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Atherosclerosis

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction
Diabetes Mellitus

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D-12849	29d. DATE SIGNED (Month, Day, Year): ▶ 8-22-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.M. Ghiladi M.D. 7600 Osler Dr. Towson, Md. 21204		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23535 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEROY J. MOORE JR.					2. DATE OF DEATH (Month, Day, Year): AUGUST 27, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 217-34-9288	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 1/26/1931	8. BIRTHPLACE (State or Foreign Country): N. CAROLINA
9a. FACILITY NAME (If not institution, give street and number): 2521 EMERSON STREET,			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MARYLAND		9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT						
10a. STATE: MARYLAND	10b. COUNTY:		10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 2521 N. EMERSON STREET, BALTIMORE, MD.			10f. ZIP CODE: 21229		10g. CITIZEN OF WHAT COUNTRY: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSTRUCTION WORK		16b. KIND OF BUSINESS/INDUSTRY: SELF EMPOLYER	
17. FATHER'S NAME (First, Middle, Last): LEROY MOORE			18. MOTHER'S NAME (First, Middle, Maiden Surname): CONNIE WILLIAM			
19a. INFORMANT'S NAME (Type/Print): MERTINA SMITH			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 N.MONASTERY AVE, BALTIMORE, MARYLAND 21223			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY		20c. LOCATION — City or Town, State: BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]			22. NAME AND ADDRESS OF FACILITY: ESTEP BROTHERS FUNERAL SERVICE, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. END-STAGE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF): & prob myocardial infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined			1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD / TRAUMA		▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAUL BALBOTAS M.D. 900 CATON AVENUE BALTO 21229

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
08/AUG 30 1989	[signature]

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23536
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending ... Burial/Transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a ... page 4 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTHA Mae MILLER			2. DATE OF DEATH (Month, Day, Year): August 28, 1989	3. TIME OF DEATH: 7:15 P. M
4. SOCIAL SECURITY NUMBER: 215-07-2946	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8-24-1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 5310 Remmell Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5310 Remmell Ave.		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHite

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Yrs. / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): John Kehl, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mollie Fabiszak	
19a. INFORMANT'S NAME (Type/Print): David Miller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6206 Moyer Ave., Baltimore, Md. 21206	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 9-1-89	20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather (Roy H. Cather)	22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Heart Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Warren Israel MD	29c. LICENSE NUMBER: D17803	29d. DATE SIGNED (Month, Day, Year): 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Warren Israel, M.D. 8417 Bellona Lane Baltimore, Md.

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-t5 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23537

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUDOLPH F. NOVAK, JR.			2. DATE OF DEATH: MONTH 08 DAY 26 YEAR 89	3. TIME OF DEATH: 5:45 a M
4. SOCIAL SECURITY NUMBER: 2]5-0]-588]	5. SEX: X M 2 F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year):]2-04-]4	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: TOWSON

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Lutherville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 7202 North Charles Street		10f. ZIP CODE: 21093	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed	16b. KIND OF BUSINESS/INDUSTRY: Garage Business
17. FATHER'S NAME (First, Middle, Last): Rudolph F. Novak, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Antoine UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): Ronald R. Novak		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same As #10	
20a. METHOD OF DISPOSITION: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gards. 8-29-89	20c. LOCATION — City or Town, State: Timonium, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks, Jr.		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. MESTASTATIC PROSTATIC CANCER
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Olakunle D. Ajanaku MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR OLAKUNLE D AJANAKU G.B.M.C.		
31. DATE FILED (Month, Day, Year): AUG 3 0 1989	32. REGISTRAR'S SIGNATURE: Juha Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23538
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Bernard Nelson , Sr.
2. DATE OF DEATH (Month, Day, Year): 8 26 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 577-32-9765
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/18/1929
8. BIRTHPLACE (State or Foreign Country): Washington, D.C.
9a. FACILITY NAME (If not institution, give street and number): 12 East Lake Ave.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore, City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 12 East Lake Ave.
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): , 4
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Architect
16b. KIND OF BUSINESS/INDUSTRY: Self Employed
17. FATHER'S NAME (First, Middle, Last): Augustus Nelson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Magdalene Flaharty
19a. INFORMANT'S NAME (Type/Print): Ethel A. Nelson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley 8/30/89
20c. LOCATION — City or Town, State: Timonium, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald C. Ruck Sr.
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic small cell cancer

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter Koppel MD
29c. LICENSE NUMBER: D15538
29d. DATE SIGNED (Month, Day, Year): 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Walter B. Koppel 1900 East Northern Pkwy. Balto. Md. 21239
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

2

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23539

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The burial-transit permit. Pages 1, 2, 3 should
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy Mae Oliver			2. DATE OF DEATH (Month, Day, Year): 8-27-89	3. TIME OF DEATH: 2:04PM M
4. SOCIAL SECURITY NUMBER: 228-54-9153	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 50 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 1/27/39	8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 926 E. BIDDLE STREET		10f. ZIP CODE: 21202		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC
17. FATHER'S NAME (First, Middle, Last): EARL BLAND		18. MOTHER'S NAME (First, Middle, Maiden Surname): GOLDIE CAMPBELL		
19a. INFORMANT'S NAME (Type/Print): SHEILA OLIVER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4025 RAVEN ROAD/RANDALLSTOWN, MD 21133		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FAMILY PLOT		20c. LOCATION — City or Town, State: CREW, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warren		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertensive arteriosclerotic cardiovascular disease and chronic

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): XXXXXXXXXXXXXXXXXX ethanol abuse
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XXX YES 2 ☐ NO	XXX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
XXX YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 XXX ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
XXX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Julia C. Goodin, M.D.	OCME	▶ 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23540
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willie Mae Penn			2. DATE OF DEATH: MONTH 08 DAY 25 YEAR 1989	3. TIME OF DEATH: 11:41 PM
4. SOCIAL SECURITY NUMBER: 069-12-3601	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar 1, 1900	8. BIRTHPLACE (State or Foreign Country): Georgia
8a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3610 Loch Raven Blvd.		10f. ZIP CODE: 21218		10g. CITIZEN OF WHAT COUNTRY? U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 15 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed		16b. KIND OF BUSINESS/INDUSTRY: Cosmotology
17. FATHER'S NAME (First, Middle, Last): Walter Cummings Maben		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Thomas		
19a. INFORMANT'S NAME (Type/Print): Dr. John R. Maben		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3610 Loch Raven Blvd. Baltimore, Maryland 21218		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery		20c. LOCATION — City or Town, State: Baltimore County, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest Terry Nutter		22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltiore, Maryland 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hasrt fsilure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ventricular Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Ventricular Failure
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Sabah Ali Al-Attar, M.D.		▶ 08/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sabah Ali Al-Attar, M.D., Liberty Medical Ctr., Baltimore, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23541
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHRISTY T. PALMERI — Christy T. Palmeri
2. DATE OF DEATH (Month, Day, Year): 08 28 89
3. TIME OF DEATH: 6:15A M
4. SOCIAL SECURITY NUMBER: 218-12-2618 A
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 8, 1907
8. BIRTHPLACE (State or Foreign Country): Penn.
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3500 Woodlea Ave.
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs — College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Vincenzio Palmeri
18. MOTHER'S NAME (First, Middle, Maiden Surname): Concetta Palmeri
19a. INFORMANT'S NAME (Type/Print): Mr. Guy Palmeri
19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1203 Old Mountain Road South Joppa, Md. 21085
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery 8/30/89
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. — Paul L. Hartsock, Jr.
22. NAME AND ADDRESS OF FACILITY: Baltimore, Maryland 21214 — Leonard J. Ruck, Inc. 5305 Harford Rd.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	UROSEPSIS	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	S/P CEREBRO VASCULAR ACCIDENT	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	H/O CORONARY ARTERY DISEASE	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINDS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: D33215
29d. DATE SIGNED (Month, Day, Year): 08/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23542

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained for hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HELEN E. QUICK
2. DATE OF DEATH (Month, Day, Year): 08 27 1989
3. TIME OF DEATH: 2:30 AM
4. SOCIAL SECURITY NUMBER: 188-07-1356 D
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07-16-1908
8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): 5155 BARTHOLOW RD.
9b. CITY, TOWN OR LOCATION OF DEATH: SYKESVILLE
9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CARROLL
10c. CITY, TOWN OR LOCATION: SYKESVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5155 BARTHOLOW Rd.
10f. ZIP CODE: 21784
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): FULL — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: HOME MAKER
17. FATHER'S NAME (First, Middle, Last): JOHN HUNTER
18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA ODESSA SMITH
19a. INFORMANT'S NAME (Type/Print): NAOMI DICKEY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5155 BARTHOLOW RD SYKESVILLE, MD. 21784
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SAMS CREEK CEMETARY
20c. LOCATION — City or Town, State: NEW WINDSOR
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight
22. NAME AND ADDRESS OF FACILITY: HAIGHT F.H. Box 195 Sykesville, MD. 21784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Pulmonary Edema	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Ischemic Heart Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Hypertension	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward Sherman
29c. LICENSE NUMBER: D19171
29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward Sherman MD 5620 Liberty Rd 21784 Carroll MD 21133
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Tomlinson-Pendleton

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23543

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Yvonne Ransome				2. DATE OF DEATH: MONTH 8 DAY 28 YEAR 89	3. TIME OF DEATH: 4:45PM M
4. SOCIAL SECURITY NUMBER: 241-94-6107	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 34 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11/17/54	8. BIRTHPLACE (State or Foreign Country): NC
9a. FACILITY NAME (If not institution, give street and number): 2816 Montebello Terrace			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2816 MONTEBELLO TERRACE 1st			10f. ZIP CODE: 21214		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): RAY MATTHEWSON			18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA PETTAWAY		
19a. INFORMANT'S NAME (Type/Print): DANIEL RANSOME, JR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2816 MONTEBELLO TERRACE/BALTIMORE, MD 21214			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTLAWN MEMORIAL PARK		20c. LOCATION — City or Town, State: TARBORO, NC	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Ramsey		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intra-abdominal hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Rupture of the ectopic pregnancy	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mario F. Golle Jr. M.D.	OCME	▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,M.D. 111 Penn Street,Baltimore, Maryland 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

OHMH-16 Rev 1/89

item 7, film G655 9-6-89 I.J

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23544

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GLORIA Y. REAVES			2. DATE OF DEATH (Month, Day, Year): 8 26 89	3. TIME OF DEATH: 5:00 P M
4. SOCIAL SECURITY NUMBER: 219-32-4114	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/27/~~39~~ 35	8. BIRTHPLACE (State or Foreign Country): N. CAROLINA
9a. FACILITY NAME (If not institution, give street and number): University Hospital - STU		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: LAUREL	10c. CITY, TOWN OR LOCATION:	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9225 STRADER'S CROSSING, APT-K		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): JAMES WITHERSPOON	18. MOTHER'S NAME (First, Middle, Maiden Surname): ALMA BLAKELEY
19a. INFORMANT'S NAME (Type/Print): UVEL E. REAVES	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 411 OLD STAGE RD, APT F: GLEN BURNIE, MD 21061
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOW RIDGE
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett	22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries with complications	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO Inspection	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-4-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: driver in auto/auto impact
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Donaldson Ave & Rt. 170, A.A.Co.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street Baltimore, Md. 21201

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR XC 9686538

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23545

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD R. REITER			2. DATE OF DEATH (Month, Day, Year): AUGUST 27, 1989	3. TIME OF DEATH: 12:40 P M
4. SOCIAL SECURITY NUMBER: 213 05 6036	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/02/18	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): V.A. MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: FORT HOWARD		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 500 N. STUART STREET		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW11	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify:

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MAILMAN	16b. KIND OF BUSINESS/INDUSTRY: POSTAL

17. FATHER'S NAME (First, Middle, Last): JOHN REITER	18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA MC NAMARA
19a. INFORMANT'S NAME (Type/Print): CLINICAL RECORDS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): VAMC, FORT HOWARD, MARYLAND 21052

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc.	20c. LOCATION — City or Town, State: Baltimore MAryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home	22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MaceAve. 21221	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Bronchopneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive Cardiac Failure due to Ischaemic Heart Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Neel Kamal MD	29c. LICENSE NUMBER: D36409	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NELL KAMAL, M.D. VAMC FORT HOWARD, MARYLAND 21052		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23546
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie Russ
2. DATE OF DEATH (Month, Day, Year): 8 27 89
3. TIME OF DEATH: 1:09 a M
4. SOCIAL SECURITY NUMBER: 218-58-6807
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 ~~83~~ YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. 10
7. DATE OF BIRTH (Month, Day, Year): 8 ~~29~~ 06
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, md.
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Dundalk
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3517 Dunhaven Road
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Thomas Soul
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna ====
19a. INFORMANT'S NAME (Type/Print): Erma Freburger
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3509 Dunhaven Road Baltimore MAryland 21222
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Morelands Cemetery
20c. LOCATION — City or Town, State: BAlto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ruptured Abdominal Aortic Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. massive hemorage
DUE TO (OR AS A CONSEQUENCE OF):
c. acute rupture Abdominal Aorta Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8/26/89
28b. TIME OF INJURY: Bet 4p M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] Jacobs
29c. LICENSE NUMBER: D 37027
29d. DATE SIGNED (Month, Day, Year): 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Francis Scott Key Med Ctr
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rendon

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23547 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances Robinsen				2. DATE OF DEATH (Month, Day, Year): 8 22 89	3. TIME OF DEATH: 5:20 P M	
4. SOCIAL SECURITY NUMBER: 220-14-2918	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): ~~68~~ 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/27/20	8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Balto City	
RESIDENCE OF DECEDENT						
10a. STATE: Md.	10b. COUNTY:		10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 3309 Elgin Ave.			10f. ZIP CODE: 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Frank Gladden			18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Sheridan			
19a. INFORMANT'S NAME (Type/Print): Carolyn Dungee			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2839 Clifton Ave. Balto. Md. 21216			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. Veterans		20c. LOCATION — City or Town, State: Crownsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Cecil C Estep			22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Place Balto. Md. 21217			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hepatorenal Failure	1 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
I. Weinby MD PhD, Jr Asst Resident	9312	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Irving Weinberg MD PhD.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
8/22 AUG 30 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

17

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23548

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rosenthal, Catherine J			2. DATE OF DEATH (Month, Day, Year): 8 23 1989	3. TIME OF DEATH: 0520 M
4. SOCIAL SECURITY NUMBER: 219-44-8940	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 44 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 4/22/45	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Saint Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Maryland		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Maryland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 304 Overbrook Road		10f. ZIP CODE: 21212	10g. CITIZEN OF WHAT COUNTRY? United STates

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): XXXXXX Cashier	16b. KIND OF BUSINESS/INDUSTRY: Retail	
17. FATHER'S NAME (First, Middle, Last): Calvin Conrad Jubb		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Alice O'Rourke	
19a. INFORMANT'S NAME (Type/Print): A. Vaughn Rosenthal	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 Overbrook Road Balto Md 21212		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley	20c. LOCATION — City or Town, State: Lutherville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis S. Xenakis	22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Subarachnoid hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ruptured Berry Aneurysm	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINDS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XXX YES 2 ☐ NO	XXX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XXX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XXX ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: XXX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Charles P. Kokes MD	OCME	▶ 8-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

Item#18 per FH film 654 8/31/89fj

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23549

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert William Shenton		2. DATE OF DEATH (Month, Day, Year): August 28, 1989	3. TIME OF DEATH: 8:30 P M
4. SOCIAL SECURITY NUMBER: 219-26-7481	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov 2, 1938
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): 702 Chapelridge Road	9b. CITY, TOWN OR LOCATION OF DEATH: Lutherville	9c. COUNTY OF DEATH: Baltimore Co.	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Lutherville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 702 Chapelridge Road	10f. ZIP CODE: 21093	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ / College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Analyst	16b. KIND OF BUSINESS/INDUSTRY: Social Security Administration	
17. FATHER'S NAME (First, Middle, Last): Oda Matthew Shenton	18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn B. Wells		
19a. INFORMANT'S NAME (Type/Print): Barbara Harman Shenton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 702 Chapelridge Road, Lutherville, MD 21093		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakeview Memorial Park	20c. LOCATION — City or Town, State: Eldersburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson	22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Lutherville, MD 21093		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. 38 Cal Bullet Wound of Head	Sudden
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): Aug 28, 1989	28b. TIME OF INJURY: 30 M	28c. INJURY AT WORK? 1 ☐ YES 2 X NO
	28d. DESCRIBE HOW INJURY OCCURED: 38 Cal Bullet To Head		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home-702 Chapel Ridge Rd	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Timonium Md	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell MD	29c. LICENSE NUMBER: D-09383	29d. DATE SIGNED (Month, Day, Year): ▶ August 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell MD - 7501 York Rd Towson Md 21204		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Gitte Davidson-Randall	

30

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23550

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert W. Suman		2. DATE OF DEATH (Month, Day, Year): 08 27 89	3. TIME OF DEATH: 8:30 PM
4. SOCIAL SECURITY NUMBER: 214-03-2849	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 10-26-1917
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, MD	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8314 Overmont Rd.	10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Serviceman	16b. KIND OF BUSINESS/INDUSTRY: Allied Chemical-Bendix	
17. FATHER'S NAME (First, Middle, Last): Robert W. Suman, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith Isabell Saffell	
19a. INFORMANT'S NAME (Type/Print): Doris C. Suman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8314 Overmont Road Baltimore, Maryland 21234		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery	20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lassahn Funeral Home	22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd	Balto., Md. 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC LARGE CELL LUNG CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D33215	29d. DATE SIGNED (Month, Day, Year): ▶ 08/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23551 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained ... or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ... case as the burial-transit permit. Pages 1, 2, 3 should

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified ... once.

D

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Geraldine Storck — Geraldine M. Storck			2. DATE OF DEATH (Month, Day, Year): August 27 1989	3. TIME OF DEATH: 9:35 P M
4. SOCIAL SECURITY NUMBER: 217-24-0392	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-18-29	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1138 E. Riverside Ave.		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor	16b. KIND OF BUSINESS/INDUSTRY: Eastern Stainless	
17. FATHER'S NAME (First, Middle, Last): George Holdorf		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Kalb	
19a. INFORMANT'S NAME (Type/Print): William Storck		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1138 E. Riverside Ave. Balto. Md. 21221	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery	20c. LOCATION — City or Town, State: Baltimore Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home		22. NAME AND ADDRESS OF FACILITY: Connelly funeral Home 300MaceAve. 21221	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intraparenchymal bram hemorrhage	24 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension	1 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-26-89	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: Sudden loss of consciousness		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomison MD / Crawford	29c. LICENSE NUMBER: D32553	29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L. Morrison Francis Scott Key Hospital			
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Jane Davidson-Randall		

DHMH-16 Rev 1/89

89 23552

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before ...

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jennie L. STAGG			2. DATE OF DEATH (Month / Day / Year): 08 / 28 / 89	3. TIME OF DEATH: 11:26 P.M
4. SOCIAL SECURITY NUMBER: 153-14-4523	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): July 21, 1905	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Sparks	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 15200 Priceville Rd.	10f. ZIP CODE: 21152	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Arthur Simpson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Aurdick	
19a. INFORMANT'S NAME (Type/Print): Carole Fisher		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15200 Priceville Rd., sparks, MD 21152	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): East Ridgelawn	20c. LOCATION — City or Town, State: Clifton, N.J.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Altenburg		22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic heart disease with	
DUE TO (OR AS A CONSEQUENCE OF):	Probable senile organic psychosis	→ years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lawrence F. Quigley MD	29c. LICENSE NUMBER: D000391	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LAWRENCE F. QUIGLEY M.D. 120 SISTER PIERRE DR. TOWSON 21204

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Item 23 part I, 28a,c,d,e,f & 27 corrected per Med. Exam.
Film G-655 09/16/89 pjt

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23553 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Jerome	Thomas	8 / 12 / 89	1:30 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-64-0857	1 ☑ M 2 ☐ F	35 YRS.			10-9-53	BALT. MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
725 George Street	Baltimore	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD.		BALT.	1 ☑ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1058 ARGYLE AVE BALT. MD.		USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEHDEHT OF HISPAHIC ORIGIH? (Specify Yes or Ho— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☑ NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIHD OF BUSIHESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		N/A	N/A

17. FATHER'S HAME (First, Middle, Last)	18. MOTHER'S HAME (First, Middle, Maiden Surname)
UNKNOWN	UNKNOWN

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DIANNE BLACK	3407 AMOEA LANE BALT. MD

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	WESTER STAR CEM.	BALT. MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. HAME AHD ADDRESS OF FACILITY
▶ Gary L. Collins	WUTTER FUN. HOME 2501 Guilford Ave Balt. MD 21218

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Narcotic and alcohol intoxication	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUEHCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AH AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☑ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☑ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) house

27. MAHHER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined	found: 8-12-89	M	1 ☐ YES 2 ☒ NO	Unknown

28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
found: In an apartment	found: 725 George St. Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYIHG PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE HUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	OCME	▶ 8/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. - Deputy Chief 111 Penn St. Balto.MD.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	[signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23554
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 must be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James R. Tucker			2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: 1:30p M
4. SOCIAL SECURITY NUMBER: 228-28-4713	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/14/26	8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1319 MYRTLE AVENUE		10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): EMBRY TUCKER			18. MOTHER'S NAME (First, Middle, Maiden Surname): DEANNA BEARD	
19a. INFORMANT'S NAME (Type/Print): ANNA BLACKBURN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 840 HARLEM AVENUE/BALTIMORE, MD 21217		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM		20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertensive atherosclerotic cardio vascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Fraction of left hip

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
Approval

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
8-17-89	8:14AM	1 [ ] YES 2 [X] NO	Subject fell at home

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
home	840 Harlem Avenue, Baltimore, MD

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jeffrey A Bennion MD	n/a	▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jeffrey Bennion, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23555 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edith M. Stevens
2. DATE OF DEATH (Month, Day, Year): August 25 1989
3. TIME OF DEATH: 8:30P M
4. SOCIAL SECURITY NUMBER: 219-20-7805
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/22/1913
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Balto.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Balto.
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10a. STREET AND NUMBER: 125 Versailles Circle
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 8 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Frank Miller
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Lambrecht
19a. INFORMANT'S NAME (Type/Print): F. Duncan Cornell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 West Pennsylvania Ave. Towson, Md. 21204
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Grdns 8/30/89
20c. LOCATION — City or Town, State: Timonium, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald C. Schade Sr.
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	1± Month
DUE TO (OR AS A CONSEQUENCE OF): b.	Metastatic Endometrial Carcinoma	2± yr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell
29c. LICENSE NUMBER: D-09383
29d. DATE SIGNED (Month, Day, Year): ▶ August 26, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell MD-7501 York Rd Towson Md 21204
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Kramer

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23556
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

D

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) HELENE C. TODD			2. DATE OF DEATH MONTH 08 DAY 25 YEAR 89	3. TIME OF DEATH 2:00 P M
4. SOCIAL SECURITY NUMBER 220-07-1575	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 68 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-25-20	8. BIRTHPLACE (State or Foreign Country) MD.
9a. FACILITY NAME (If not institution, give street and number) ST JOSEPH HOSPITAL INC		9b. CITY, TOWN OR LOCATION OF DEATH 7620 YORK ROAD TOWSON		9c. COUNTY OF DEATH BALTO.

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Towson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 738 Camberley Circle		10f. ZIP CODE 21204	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Detective	16b. KIND OF BUSINESS/INDUSTRY Baltimore County Police	
17. FATHER'S NAME (First, Middle, Last) William Lannon		16. MOTHER'S NAME (First, Middle, Maiden Surname) Dellia Garvey	
18a. INFORMANT'S NAME (Type/Print) Clarence F. Todd	18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Kreitler Valley Rd., Forest Hill, Md. 21050		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery 8-29-89	20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Wallace S. Brooks Jr.	22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NON Q-WAVE INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ISCHEMIC CONGESTIVE CARDIOMYOPATHY	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D33215	▶ 08/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Kopacka

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23557
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS M. TAYLOR
2. DATE OF DEATH (Month, Day, Year): 8 28 1989
3. TIME OF DEATH: 8:25 P M
4. SOCIAL SECURITY NUMBER: 087 12 9771 A
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 6, 1915
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5910 Brackenridge Ave.
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Conductor
16b. KIND OF BUSINESS/INDUSTRY: Railroad
17. FATHER'S NAME (First, Middle, Last): James F. Taylor
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Agnes Taylor
19a. INFORMANT'S NAME (Type/Print): Mrs. Edith B. Taylor
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5910 Brackenridge Ave. Baltimore, Md. 21212
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ackerman Kenny Jr
22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pulmonary edema	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Severe pneumonia	4 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Chronic Renal Failure
Chronic Obstructive Pulmonary Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Coomes M.D. House Staff
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Coomes, M.D. Union Memorial Hospital 201 E. University Parkway Baltimore, Md. 21218
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23558
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AMELIA CHRISTINE VLCEK ~~XXXXX~~
2. DATE OF DEATH (Month, Day, Year): AUGUST 29, 1989
3. TIME OF DEATH: 1:15 a M
4. SOCIAL SECURITY NUMBER: 213-03-5419D
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 10, 1902
8. BIRTHPLACE (State or Foreign Country): Czechoslavakia
9a. FACILITY NAME (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 501 W. Franklin St.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Frank Michal
18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline Hillen
19a. INFORMANT'S NAME (Type/Print): Winifred Hata
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3223 Chesley Ave., Baltimore, MD 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. George Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	RIGHT LOWER LOBE PNEUMONIA	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	RESPIRATORY ARREST	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CHRONIC HEART FAILURE
DEMENTIA SCHIZOPHRENIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas C. Teather
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 8-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS TEATHER c/o MARYLAND GENERAL HOSPITAL
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 1o,10e,10f,19e, film G655 9-6-89- I.J.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23559

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Wilson, Theodore R.
2. DATE OF DEATH: MONTH 08 DAY 27 YEAR 89
3. TIME OF DEATH: 3:30pm
4. SOCIAL SECURITY NUMBER: 214 22 5373
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 61 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/17/27
8. BIRTHPLACE (State or Foreign Country): NC
9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
LOCATION: ~~SEVERN~~ ~~SEVERNA~~ PARK
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND: 907 S. ~~WICKER~~ WIEKER ROAD
10f. ZIP CODE: ~~21146~~ 21144
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ASSEMBLY LINE
16b. KIND OF BUSINESS/INDUSTRY: GENERAL MOTORS
17. FATHER'S NAME (First, Middle, Last): ROLAND WILSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): SALLIE STRONG
19a. MABLE (Type/Print) ~~MABEL~~ JACKSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1005 BONAPARTE AVENUE/BALTIMORE, MD 21218
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTO. NAT'L VET. CEM.
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular collapse
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Lung adenocarcinoma w/m metatses — Oct 88
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C.J Haslam MD (intern)
29c. LICENSE NUMBER: MR 0425
29d. DATE SIGNED (Month, Day, Year): ▶ 27th Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CATHERINE JANE HASLAM MD
31. DATE RECEIVED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23560
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERNARD L. WEINER				2. DATE OF DEATH: MONTH 08 DAY 28 YEAR 89	3. TIME OF DEATH: 1:00 A. M
4. SOCIAL SECURITY NUMBER: 119-20-4851	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 09-06-29	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Dock St. and Waterfront (Home)			9b. CITY, TOWN OR LOCATION OF DEATH: Crisfield		9c. COUNTY OF DEATH: Somerset

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: Crisfield	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Dock St. and Waterfront		10f. ZIP CODE: 21817	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 12-23-46 / 09-22-49	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): H.S. Graduate; College (1-4 or 6+): - -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner	16b. KIND OF BUSINESS/INDUSTRY: Retail Seafood Establishment	
17. FATHER'S NAME (First, Middle, Last): Jack Weiner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne Lefkowitz	
19a. INFORMANT'S NAME (Type/Print): Bart Weiner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1760 N. Rhodes St.,- Unit 344,-Arlington,VA 22201	
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Quantico National Cemetery	20c. LOCATION — City or Town, State: Triangle, VA 22172	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert L. Bradshaw		22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home, 306 W. Main St., Crisfield, MD 21817	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	instant
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Diabetes Mellitus	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Endogenous obesity

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Sterling, M.D.	29c. LICENSE NUMBER: D 10214	29d. DATE SIGNED (Month, Day, Year): ▶ 08-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Sterling, M.D. - 320 W. Main St. - Crisfield, MD 21817		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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DHMH-1 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23561

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Wiley Ivey		2. DATE OF DEATH (Month, Day, Year): 8 24 1989	3. TIME OF DEATH: 0602 M
4. SOCIAL SECURITY NUMBER: 242-03-7309	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 9/6/05
8. BIRTHPLACE (State or Foreign Country):			
9a. FACILITY NAME (If not institution, give street and number): Harbor Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1409 Ward Street		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Ben ☑ Ivey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Ivey	
19a. INFORMANT'S NAME (Type/Print): Elnora Ivey	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1409 Ward St. Baltimore, Md. 21230		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	20c. LOCATION — City or Town, State: Arbutus, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Carl A Estep	22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Overwhelming Urosepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Renal Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pancreatic Carcinoma with Liver Metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29c. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: I.M. Ndukwe, MD	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ikeadi M. Ndukwe, MD Harbor Hospital center Baltimore, MD 21230

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23562

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Julia Hazel Wright				2. DATE OF DEATH: MONTH 8-25-89 DAY YEAR	3. TIME OF DEATH: 6:12 p M
4. SOCIAL SECURITY NUMBER: 218-10-1550	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-26-20	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore County	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Baltimore County	10c. CITY, TOWN OR LOCATION: Towson		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 617 Charles Street Avenue		10f. ZIP CODE: 21204		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Clothing/Manufacturing			
17. FATHER'S NAME (First, Middle, Last): Thomas Jesse Wright		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Estelle Lovell			
19a. INFORMANT'S NAME (Type/Print): Mrs. Emma Hirsch		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 617 Charles Street Ave. Towson, Md. 21204			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery		20c. LOCATION — City or Town, State: Parkville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John G. Reitz		22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Infarction	hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Cardiovascular Disease	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26l. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] ATTENDING MD.

29c. LICENSE NUMBER: D16965

29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 6506 PARK HEIGHTS AVE BALTO MD 21215

31. DATE FILED (Month, Day, Year): AUG 30 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1-1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23563
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 ... be filled by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles R. Werner		2. DATE OF DEATH (Month, Day, Year): 8-24-89	3. TIME OF DEATH: 1708. P.M.
4. SOCIAL SECURITY NUMBER: 213-18-3624	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-1-20
8. BIRTHPLACE (State or Foreign Country): 69			

9a. FACILITY NAME (If not institution, give street and number): CARROLL CO. GENERAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: Westminster	9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: Sykesville md	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 7309 Second Ave.	10f. ZIP CODE: 21784	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales	16b. KIND OF BUSINESS/INDUSTRY: Auto	

17. FATHER'S NAME (First, Middle, Last): Alfred M. Werner	18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude Catiz

19a. INFORMANT'S NAME (Type/Print): Mrs. Mabel Sommers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1434 Dartmouth Ave. Baltimore, Md. 21234

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Herman Kenny Jr.	22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY FAILURE	12 mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEVERE Chronic Obstructive Lung Disease many yrs	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Upper GI Bleed. Hemisphilus Influenza Bronchitis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: N. Patpara MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 8 24 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. PATPARA. 217 WASHINGTON HTS. WESTMINSTER MD 21157.

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23564

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Items 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William R. Bowie III			2. DATE OF DEATH (Month, Day, Year): 8-28-89	3. TIME OF DEATH: 2:46AM M
4. SOCIAL SECURITY NUMBER: 217-50-4727	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 42 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12- 4-1946	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3026 Windsor Avenue		10f. ZIP CODE: 21216	10g. CITIZEH OF WHAT COUHTRY?: U S A

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDEHT EVER IH U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECEHDENT OF HISPAHIC ORIGIN? (Specify Yes or Ho— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] HO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSIHESS/IHDUSTRY
17. FATHER'S HAME (First, Middle, Last): William R. Bowie, Jr		18. MOTHER'S HAME (First, Middle, Maiden Surname): Nellie Harris	
19a. INFORMANT'S NAME (Type/Print): William R. bowie, Jr		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3026 Windsor Avenue Baltimore, Md 21216	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park	20c. LOCATION — City or Town, State: Catonsville, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Ebron		22. NAME AHD ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Blunt force injuries of chest and head
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUEHCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XXX 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX 1 [X] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XXX 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Hursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-27-89	28b. TIME OF INJURY: 9:25PM	28c. INJURY AT WORK? 1 [ ] YES XXX [X] HO	28d. DESCRIBE HOW INJURY OCCURED: Subject beaten (assaulted by baseball bat
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 300 blk. W. Fayette Street, Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C Goodin M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201		VC
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23565
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jerry BARNES					2. DATE OF DEATH (Month / Day / Year): 08 / 25 / 89		3. TIME OF DEATH: 10:30 PM
4. SOCIAL SECURITY NUMBER: 212-44-5167	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 43 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08/03/46		8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Sinai Hosp. of Baltimore			9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE: MD	10b. COUNTY		10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 5131 Pembridge Ave.			10f. ZIP CODE: 21215			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Avon L. Washington			18. MOTHER'S NAME (First, Middle, Maiden Surname): Coatelia Barnes				
19a. INFORMANT'S NAME (Type/Print): Coatelia Washington			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2809 W. Garrison Ave Balto, Md				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park			20c. LOCATION — City or Town, State: Arbutus, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Portia Glover			22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest	2 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. AIDS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pneumocystic Carinii Pneumonia suspected	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	26c. INJURY AT WORK?	26d. DESCRIBE HOW INJURY OCCURED
	M	1 [ ] YES 2 [ ] NO	

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hassan-Ghaza L, Housestaff	9314	08/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

ITEM #1 FILM #G655 9/7/89 J. A. PER: F. H

89 23566

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~BABY BOY~~ ~~DARYL~~ DARYL L. BATTY ~~BROOKS~~			2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89	3. TIME OF DEATH: 06:20 AM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS / DAYS 1; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8-26-89
8. BIRTHPLACE (State or Foreign Country): Md				
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSP.	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE.	9c. COUNTY OF DEATH: BALT. CITY.		

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5450 Lynview Avenue		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Daryl Batty	18. MOTHER'S NAME (First, Middle, Maiden Surname): Yolanda Brooks	
19a. INFORMANT'S NAME (Type/Print): Sylvia Owens	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5450 Lynview Avenue Baltimore, Md 21215	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery	20c. LOCATION — City or Town, State: Elkdridge, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Ebron	22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MECONIUM ASPIRATION SYNDROME	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PERSISTENT FETAL CIRCULATION	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Martin J. Kelly MD	29c. LICENSE NUMBER: D-34731	29d. DATE SIGNED (Month, Day, Year) ▶ 8-27-89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): MARTIN J. KELLY 22 S. GREENE ST RM N5W68 BALT 21014

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

item 11, film G655 9-6-89 I.J.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23567

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James W. Bacon			2. DATE OF DEATH (Month, Day, Year): 8-29-89	3. TIME OF DEATH: 2:30p M
4. SOCIAL SECURITY NUMBER: 215-03-1131	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-29-14	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore		

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2501 Violet Avenue, Apt. 611-N	10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] ~~Never~~ Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): William E. Bacon	18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Bacon
19a. INFORMANT'S NAME (Type/Print): Mrs. Elizabeth Bacon	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2501 Violet Ave., Apt. 611-N, Balto., MD 21215

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	20c. LOCATION — City or Town, State: Balto. Co., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home, 2222-26 West North Avenue, Balto., MD 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Stomach Carcinoma.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Bilateral Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Dehydration.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D37949	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Bon Secours Hospital, 2000 W Baltimore Street, Baltimore, MD		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23568
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Alexander Bosman, Jr.			2. DATE OF DEATN: MONTH 08 DAY 28 YEAR 89	3. TIME OF DEATN: 2:30 a M
4. SOCIAL SECURITY NUMBER: 215-18-3748	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9-16-23	8. BIRTNPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATN: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Lansdowne		10d. INSIOE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 22 Clyde Avenue		10f. ZIP CODE: 21227		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — Amerlcen Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk		16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Alexander Bosman, Sr.		18. MOTNER'S NAME (First, Middle, Maiden Surname): Margaret UNKNOWN		
19a. INFORMANT'S NAME (Type/Print): June Bosman		19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 Clyde Avenue Baltimore, MD 21227		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem.		20c. LOCATION — City or Town, State: Owings Mills, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L Goff		22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory arrest DUE TO (OR AS A CONSEQUENCE OF):	5'
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Lung cancer. DUE TO (OR AS A CONSEQUENCE OF):	
	c. Acute renal failure. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Nomicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE NOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C. Alagia, M.D.	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Cohassan Alagia St Agnes Hospital 900 Caton Avenue Baltimore 21229		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rubell	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23569

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARA E. BITTNER			2. DATE OF DEATH (Month, Day, Year): 8 27 89	3. TIME OF DEATH: 920 P.M
4. SOCIAL SECURITY NUMBER: 213-34-1972	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In years last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/15/13	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3333 Chatham Road		10f. ZIP CODE: 21043		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Charles Donohue		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Buckinger		
19a. INFORMANT'S NAME (Type/Print): William F. Bittner, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7401 Swann Pt. Way Columbia, Md. 21054		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.		20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Dissection of Aortic Aneurysm.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Wilton Flowers MD	D20708	▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wilton Flowers M D 11055 Little Patuxent Columbia Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23570
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANK ANTOINE BADART
2. DATE OF DEATH — MONTH: August DAY: 21, YEAR: 1989
3. TIME OF DEATH: 4:45 P. M
4. SOCIAL SECURITY NUMBER: 214-01-8355
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/26/08
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown
9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: TALBOT
10c. CITY, TOWN OR LOCATION: EASTON
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: RT. 1, BOX 310 TUNIS MILLS
10f. ZIP CODE: 21601
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No — if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): / College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY: CLOVERLAND DAIRY
17. FATHER'S NAME (First, Middle, Last): FRANK E. BADART
18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA SHAY
19a. INFORMANT'S NAME (Type/Print): Carole Van Wie
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 Tongue Grove Dr., Lusbe, Md. 20657
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place):
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Inferior M I VENTRICULAR fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CARDIAC arrest
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
25. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mi K Ehrlich MD
29c. LICENSE NUMBER: MD 15032
29d. DATE SIGNED (Month, Day, Year): ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23571

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alfred BOLZ			2. DATE OF DEATH (Month, Day, Year): 8 / 25 / 89	3. TIME OF DEATH: 11:40 AM
4. SOCIAL SECURITY NUMBER: 577.01.2259	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08/10/14	8. BIRTHPLACE (State or Foreign Country): USA
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Med Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD		9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: DUNDALK	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ ND
10e. STREET AND NUMBER: 1942 SUNBERRY RD.		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELEC. ENGINEER	16b. KIND OF BUSINESS/INDUSTRY: C&P TELEPHONE CO.
17. FATHER'S NAME (First, Middle, Last):		18. MOTHER'S NAME (First, Middle, Maiden Surname):	
19a. INFORMANT'S NAME (Type/Print): JEAN M.H. JUNG BOLZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1942 SUNBERRY RD., DUNDALK, MD. 21222	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 6 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald McClure		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Intracranial hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of previous cerebrovascular accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8/17/89	28b. TIME OF INJURY: 6:30 AM	28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO	28d. DESCRIBE HOW INJURY OCCURED: Stroke at home
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Attending Neurologist		29c. LICENSE NUMBER: D34628	29d. DATE SIGNED (Month, Day, Year): 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAL LAURIA, MD	FSKMC	Balt. Md 21224	
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23572
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELLEN ALICE CARTER
2. DATE OF DEATH (Month, Day, Year): AUG 30, 1989
3. TIME OF DEATH: 3:45 P.M.
4. SOCIAL SECURITY NUMBER: 220-76-2923
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAY 4, 1910
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MERIDAN NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: PARKVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7717 HARFORD ROAD
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 YRS. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): WILLIAM LYFORD
18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE LYFORD
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D15452
29d. DATE SIGNED (Month, Day, Year): AUG. 31, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. C. T. BESSOT

31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23573
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Raymond Clifton Jr.
2. DATE OF DEATH (Month, Day, Year): 08 25 89
3. TIME OF DEATH: 805 A M
4. SOCIAL SECURITY NUMBER: 231-12-3927
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04/03/23
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 227 South Broadway
10f. ZIP CODE: 21231
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: World War II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Raymond Clifton
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lydia Fitzgerald
19a. INFORMANT'S NAME (Type/Print): Evelyn Wisowatz
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1658 Sherwood Ave. Balto. MD 21239
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison-Forrest Veterans
20c. LOCATION — City or Town, State: Owings Mills, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Irvin Carroll Funeral Home 1712-14 W. North Ave.

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	~~Right foot ulcers~~ Right foot ulcers	3 mo.
DUE TO (OR AS A CONSEQUENCE OF): b.	Diabetes Mellitus	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Peripheral Vascular Disease	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Aortic Stenosis, history of Cerebrovascular Accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R. A. Cooley MD MR0311 Resident
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23574

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willie L. Chambers
2. DATE OF DEATH (Month, Day, Year): 8-28-89
3. TIME OF DEATH: 8:55AM M
4. SOCIAL SECURITY NUMBER: 212 56 7054
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 37 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/1/1951
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): University Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1607 Mosher Street
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Willie Chambers
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Figgs
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy Johnson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5933 Falkirk Rd. Balto., Md. 21239
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons, 1701 Laurens St. Balto., Md. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wound of chest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8-27-89
28b. TIME OF INJURY: 9:28PM
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Subject shot
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1600 block Baker Street, Balto., Maryland
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: David F. Galle Jr. M.D.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 8-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 VC
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Romero

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23575

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETSEY R. COHEN			2. DATE OF DEATH (Month, Day, Year): AUGUST 27, 1989	3. TIME OF DEATH: 8 A.M. M
4. SOCIAL SECURITY NUMBER: 216-10-8693	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JULY 3, 1897
8. BIRTHPLACE (State or Foreign Country): NEW YORK				
9a. FACILITY NAME (If not institution, give street and number): JEWISH CONVALESCENT & NURSING HOME	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: BALTIMORE		

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3914 FORDLEIGH ROAD, APT. D	10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY	16b. KIND OF BUSINESS/INDUSTRY: CROWN CORK & BOTTLE CO.	
17. FATHER'S NAME (First, Middle, Last): SAMUEL ROSENBERG	18. MOTHER'S NAME (First, Middle, Maiden Surname): HANNAH UNKNOWN		
19a. INFORMANT'S NAME (Type/Print): MRS. SYLVIA B. LISSAUER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8504 LEONARD DRIVE SILVER SPRING, MD 20910		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SHAAREI TFILOH CEMETERY-BALTO., MD	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson	22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE MYOCARDIAL INFARCTION (probable)
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: 015140	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 6210 PARK HEIGHTS Ave, BALT, MD 21215		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 23576

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNIE MAE CLAYTON (Annie Clayton)		2. DATE OF DEATH (Month, Day, Year): 08-29-89	3. TIME OF DEATH: 0926 A M
4. SOCIAL SECURITY NUMBER: 224 09 5801	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 9, 1915
8. BIRTHPLACE (State or Foreign Country): Columbia, S.C.			
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK	9c. COUNTY OF DEATH: MOTGOMERY	
RESIDENCE OF DECEDENT			
10a. STATE: NA	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: WASHINGTON, D.C.	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3465 25th St.,S.E.	10f. ZIP CODE: 20020	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home maker	16b. KIND OF BUSINESS/INDUSTRY: private home	
17. FATHER'S NAME (First, Middle, Last): unk	18. MOTHER'S NAME (First, Middle, Maiden Surname): RINAH TAYLOR		
19a. INFORMANT'S NAME (Type/Print): GLADYS SMITH DAUGHTER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1221 Staples St.,N.E. Washington,D.C. 20002		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/2/89	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK	20c. LOCATION — City or Town, State: LANDOVER, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Alex S. Pope Jr. 174	22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOME 2617 Pennsylvania Avenue,S.E. DC 20020		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIO-PULMONARY ARREST.	several days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. CONGESTIVE HEART FAILURE & PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF): c. CHRONIC RENAL FAILURE.	YEARS.
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(i) Pleural Effusion (ii) Diabetes Mellitus (iii) severe Anemia (iv) Arteriosclerotic Cardiovascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mohammed A. Mannan MD Attending physician	29c. LICENSE NUMBER: D24593	29d. DATE SIGNED (Month, Day, Year): ▶ 8.30.89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Mohammed A. Mannan,MD 7600 Carroll Avenue,Takoma Park, Md.20012		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23577
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLETTE DAY			2. DATE OF DEATH (Month, Day, Year): AUGUST 29, 1989	3. TIME OF DEATH: 4:30 P M
4. SOCIAL SECURITY NUMBER: 219-28-3702	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/14/15	8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 633 N. AISQUITH STREET APT. 14K		10f. ZIP CODE: 21202		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC		16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): THOMAS WILLIAMS		18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE THREATTE		
19a. INFORMANT'S NAME (Type/Print): BRANDER BOOKER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 123 W. 29th STREET/BALTIMORE, MD 21218 (apt.14D)		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY		20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Willis		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coronary artery disease	2 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Charles T. Bingham, MD		▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles T. Bingham, MD, 600 N. Wolfe St., Baltimore, MD 21205

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 23578

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ABRAM C HARLES DIRECTOR				2. DATE OF DEATH (Month, Day, Year): 08 21 89	3. TIME OF DEATH: 1320 PM M
4. SOCIAL SECURITY NUMBER: 220-20-3783	6. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/12/07	8. BIRTHPLACE (State or Foreign Country): RUSSIA
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: BROOKLYN PARK			10d. INSIDE CITY LIMITS? XX 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 203 HAMMONDS LA.		10f. ZIP CODE: 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 XX Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF-EMPLOYED	16b. KIND OF BUSINESS/INDUSTRY: VENDING			
17. FATHER'S NAME (First, Middle, Last): JOSEPH MICHAEL DIRECTOR		18. MOTHER'S NAME (First, Middle, Maiden Surname): TOBIAH UNKNOWN			
19a. INFORMANT'S NAME (Type/Print): MR. BARRY A. DIRECTOR	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 296 WINTERBERRY RD. WESTMINSTER, MD 21157				
20a. METHOD OF DISPOSITION: 1 XX Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO (ARLINGTON)	20c. LOCATION — City or Town, State: BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. End Stage Ischemic Cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF):

c. Positive Coronary Angiogram

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Recep Erol MD		8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. RECEP EROL 325 HOSPITAL DRIVE #104 GLEN BURNIE, MD. 21061

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	

DHMH-16 Rev 1/89

12+1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23579 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ... Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN JOHN M. DRAGER		2. DATE OF DEATH (Month / Day / Year): 8 / 29 / 89	3. TIME OF DEATH: 12:15 AM
4. SOCIAL SECURITY NUMBER: 213-10-5197	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 29, 1915
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): University Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 28 S. Patterson Park Ave.		10f. ZIP CODE: 21231	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Baker	16b. KIND OF BUSINESS/INDUSTRY: Silber's Bakery	
17. FATHER'S NAME (First, Middle, Last): Michael Drager		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maryanna Waclawski	
19a. INFORMANT'S NAME (Type/Print): Marie C. Harper	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1206 Dulaney Valley Rd., Towson, Md. 21204		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cemetery 8/31/89	20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul L. Hartsock, Jr.	22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE MYELOGENOUS LEUKEMIA	2 wks.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: GASTROINTESTINAL BLEEDING; CANDIDEMIA; STREPTOCOCCUS PNEUMONIAE BACTEREMIA; RESPIRATORY FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Peter F. Lenehan M.D.	D37682	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER F. LENEHAN, 22 SOUTH GREENE ST, BALTIMORE, MARYLAND 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Judith Davidson-Randall

DHMH-16 Rev 1/89

241

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23580

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gilbert D. Douglass			2. DATE OF DEATH (Month, Day, Year): 8 / 29 / 89	3. TIME OF DEATH: 1:10 PM
4. SOCIAL SECURITY NUMBER: 216-16-8339	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 11/6/24	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 21 North Belnord Avenue		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY: manufacturing
17. FATHER'S NAME (First, Middle, Last): Rudolph Douglass		18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa Fogel
19a. INFORMANT'S NAME (Type/Print): Wayne L. Douglass	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2703 Stevens Court Baldwin MD 21013	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter L. Moran	22. NAME AND ADDRESS OF FACILITY: Moran Funeral Home 3000 E. Baltimore St. Balto. MD 21224	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory erreat, ahock, or heart feilure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. LUNG CARCINOMA
DUE TO (OR AS A CONSEQUENCE OF):
b. BACTEREMIA / Urinary tract Infection.
DUE TO (OR AS A CONSEQUENCE OF):
c. thrombocytopenia / Anemia / Poor Nutrition
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Niloufar Guiv MD Medical Intern	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NILOUFAR GUIV 218 N. CHARLES St. Balt., Md 21201		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23581

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET H. ECKERT					2. DATE OF DEATH (Month, Day, Year): August 29, 1989	3. TIME OF DEATH: 150 AM
4. SOCIAL SECURITY NUMBER: 216.14.7211	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 8, 1922	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore City	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2804 Hoffman Avenue		10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Lock Insulator	
17. FATHER'S NAME (First, Middle, Last): William J. Heinegger		16. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Berger	
19a. INFORMANT'S NAME (Type/Print): John A. Eckert		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2804 Hoffman Avenue, Baltimore, Md. 21227	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jamie J. Siebert		22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen BUrnie, Md. 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio-Resp. Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Colon Ca c metastatic dz to liver	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Leonardo Stroud M.D. St. Agnes Hospital, 900 Caton Ave., Baltimore, Md. 21229		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson Rhodes	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23582

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH ESLIN
2. DATE OF DEATH: MONTH 7 DAY 28 YEAR 89
3. TIME OF DEATH: 7:15P M
4. SOCIAL SECURITY NUMBER: 577-05-2703
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/4/08
8. BIRTHPLACE (State or Foreign Country): -
9a. FACILITY NAME (If not institution, give street and number): PRESIDENTIAL WOODS NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: ADELPHI
9c. COUNTY OF DEATH: HYATTSVILLE

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: HYATTSVILLE
10c. CITY, TOWN OR LOCATION: ADELPHI
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 1801 METZEROTT RD.
10f. ZIP CODE: 20783
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: -
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: -
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): - College (1-4 or 5+): -
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): -
16b. KIND OF BUSINEBS/INDUSTRY: -
17. FATHER'S NAME (First, Middle, Last): -
18. MOTHER'S NAME (First, Middle, Maiden Surname): -
19a. INFORMANT'S NAME (Type/Print): MIKE ESLIN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ALEXANDRIA, VA. (703) 237-7476
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) In-State removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute aspiration pneumonia — 24hr
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic obstructive pulmonary Disease — 10 yrs
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Myron L Lenkin MD
29c. LICENSE NUMBER: D06674
29d. DATE SIGNED (Month, Day, Year): 7/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MYRON L. LENKIN MD 2309 SHORELEDD RD WHEATON MD
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia [illegible]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23583
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNIE B. FRAZIER			2. DATE OF DEATH (Month, Day, Year): AUGUST 27, 1989	3. TIME OF DEATH: 4:20 P M
4. SOCIAL SECURITY NUMBER: 212-36-8459	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/24/38	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2111 GARRISON BLVD APT J3		10f. ZIP CODE: 21216	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NA	16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): CLAUDE ANDERSON		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY HERNANDEZ	
19a. INFORMANT'S NAME (Type/Print): MICHELLE HERNANDEZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2111 GARRISON BLVD/BALTIMORE, MD 21216	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT AUBURN CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVNEUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. carcinoma of the pancreas	11 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan Randall Duncan MD	29c. LICENSE NUMBER: E9890	29d. DATE SIGNED (Month, Day, Year) ▶ 08/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan K. Duncan MD 600 N. Wolfe Street Baltimore MD		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	21205

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23584

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Brian	Jerome	Flemming	8-20-89	4:00AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
Unknown	1 X M 2 ☐ F	25 YRS.			3/12/64	Wash.,D.C.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Rear 3507 Claire Drive	Suitland	Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	P.G.	Suitland	1 X YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2315 Brooks Dr. # 104	20746	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
XX 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 X NO	1 ☐ YES 2 X NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th		Carpet Layer	Carpet

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Kenneth J. Flemming	Jacquelin D. Sims

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jacquelin D. Flemming	2719 Lakehurst Ave.,Forestville,Md.20747

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Harmony Mem. Park 8/25/89	Landover,Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Barry A. Pratt	H.S.Washington & Sons,Inc. 4925 Burroughs Ave.,N.E.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple gunshot wounds	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XX YES 2 ☐ NO	XX ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 XX YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 XX Other (Specify) Scene

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide XXX Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	8-20-89	M	1 ☐ YES 2 XX NO	Subject shot

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
lawn	Rear 3507 Claire Dr.,Suitland, Prince Georges County,MD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 8-20-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
James Kaplan,M.D.	111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	

DHMN-18 Rev 1/89

item 20b,20c, film G657 11-22-89 I.J.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23585
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Vernon E. Flowers				2. DATE OF DEATH (Month, Day, Year): 8 30 89	3. TIME OF DEATH: ~3A M
4. SOCIAL SECURITY NUMBER: 217-24-2076	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8/5/29	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 5725 Narcissus Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: Md	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5725 Narcissus		10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Edward Flowers			18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma		
19a. INFORMANT'S NAME (Type/Print): Anna Flowers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5725 Narcissus Avenue Baltimore, Md 21215			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FORST VET		OWINGS MILLS, MD ~~Arbutus, Md~~	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sala March		22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. hypertensive Cardiovascular disease — 1 year
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. alcohol abuse
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
N/A			N/A

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Bernita C. Taylor MD	BT0703795	▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bernita C. Taylor Clinical Associates 1717 Gwynn Oak Ave Balto. Md 21207

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Julia Davidson-Pendleton

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23586

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD FISCHER *Edward Francis Fischer*
2. DATE OF DEATH (Month, Day, Year): AUGUST 28, 1989
3. TIME OF DEATH: 8:35 p M
4. SOCIAL SECURITY NUMBER: 214-30-7484
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/09/32
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): VA MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: FT HOWARD
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ----------
10c. CITY, TOWN OR LOCATION: BALTIMORE *City*
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 937 S. CLINTON STREET
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 2/17/53 - 2/8/55
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 8 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): *Laborer*
16b. KIND OF BUSINESS/INDUSTRY: *Factory*
17. FATHER'S NAME (First, Middle, Last): *Edward A. Fischer*
18. MOTHER'S NAME (First, Middle, Maiden Surname): *Anna M. Weinhold*
19a. INFORMANT'S NAME (Type/Print): CLINICAL RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): VA MEDICAL CENTER, FT HOWARD, MARYLAND 21052
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): *Sacred Heart of Jesus*
20c. LOCATION — City or Town, State: *Dundalk, Balto. Co., Md.*
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ *Charles G. Zeiler*
22. NAME AND ADDRESS OF FACILITY: *Charles S. Zeiler & Son Inc. 901 S. Conkling St.*

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ISCHAEMIC HEART DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC VENTILATING INSUFFICIENCY

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: *Neil Kimmel MD*
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ *8/29/89*
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: *Julia Davidson Randall*

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23587

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ethel M. FOX — ETHEL M. FOX
2. DATE OF DEATH (Month, Day, Year): 8-28-89
3. TIME OF DEATH: 237p M
4. SOCIAL SECURITY NUMBER: 218-10-9870
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/28/11
8. BIRTHPLACE (State or Foreign Country): MASSACHUSETTS
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2717 JENNER DR., APT. C
10f. ZIP CODE: 21209
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— H yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANAGEMENT
16b. KIND OF BUSINESS/INDUSTRY: SOCIAL SEC. ADMN.
17. FATHER'S NAME (First, Middle, Last): ISAAC FOX
18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE BRAHM
19a. INFORMANT'S NAME (Type/Print): MR. HARRY FOX
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3404 HATTON RD. BALTO., MD 21208
20a. METHOD OF DISPOSITION: XXXX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SHAAREI TFILOH
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic small cell carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hepatic failure
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sie K. Ong MD House Physician
29c. LICENSE NUMBER: D36456
29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sie Kie Ong MD Baltimore County General Hospital, Randallstown, MD 21133
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMM-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23588

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Stanley Robert Fisher / STANLEY R FISHER			2. DATE OF DEATH (Month, Day, Year): 8 28 89	3. TIME OF DEATH: 4:20 A M
4. SOCIAL SECURITY NUMBER: 234 34 1173	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 6, 1905	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11511 Lund Place		10f. ZIP CODE: 20902		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Business Manager		16b. KIND OF BUSINESS/INDUSTRY: Sayre Transportation
17. FATHER'S NAME (First, Middle, Last): Sanford Fisher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Richardson		
19a. INFORMANT'S NAME (Type/Print): Doris W. Fisher (wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jefferson Memorial Park		20c. LOCATION — City or Town, State: Allegheny Co., PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David L. Sauers		22. NAME AND ADDRESS OF FACILITY: David L. Sauers Funeral Home, Falls Church, VA		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Metastic carcinoma of lungs

DUE TO (OR AS A CONSEQUENCE OF):

c. Carcinoma of colon

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: D11024	29d. DATE SIGNED (Month, Day, Year): 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD, 8805 Conn. Ave. Chevy Chase MD

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23589

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): David Green					2. DATE OF DEATH (Month, Day, Year): 8 28 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216-12-7991	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-1-19	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 4003 Carlisle Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore			9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4003 Carlisle Avenue		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY? U S A

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): OLIVER GREEN	18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie L. Allen	
19a. INFORMANT'S NAME (Type/Print): Fannie Green	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3915 Calloway Avenue Baltimore, Md 21215	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	20c. LOCATION — City or Town, State: Arbutus, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March	22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer Lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Informed by medical examiner

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Atiqur Rahman	29c. LICENSE NUMBER: D-15403	29d. DATE SIGNED (Month, Day, Year): 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3449 WILKENS Ave, Balt, Md. 21229		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23590
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOLA C. GIBSON			2. DATE OF DEATH (Month / Day / Year): 08 27 89	3. TIME OF DEATH: 1:55 PM
4. SOCIAL SECURITY NUMBER: 214-64-0908	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-13-1922	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Md	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1816 N. Payson Street		10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Coke Gilliam		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Sawyer		
19a. INFORMANT'S NAME (Type/Print): Curtis C. Gibson, Sr		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1816 N. Payson Street Baltimore, Md 21217		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet		20c. LOCATION — City or Town, State: Owings Mills, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Portia Ebron		22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: multiple sclerosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charlene Ozanne-Blackford, MD	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): 08/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charlene Ozanne-Blackford, MD 201 E. Univ. Parkway Baltimore, MD 21218

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23591

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hyman (HYMAN GAMERMAN) GAMERMAN
2. DATE OF DEATH (Month, Day, Year): 8/26/89
3. TIME OF DEATH: 2:20 A M
4. SOCIAL SECURITY NUMBER: 220-07-2900
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAY 12, 1912
8. BIRTHPLACE (State or Foreign Country): Poland

9a. FACILITY NAME (If not institution, give street and number): Homewood Hospital Center, South Baltimore
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2408 SMITH AVE.
10f. ZIP CODE: 21208
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MERCHANT
16b. KIND OF BUSINESS/INDUSTRY: RETAIL

17. FATHER'S NAME (First, Middle, Last): ISRAEL GAMERMAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA UNKNOWN

19a. INFORMANT'S NAME (Type/Print): MRS. YETTA GAMERMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2408 SMITH AVE. BALTO., MD 21208

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BNAI ISRAEL CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF): b.	Atherosclerotic Coronary Heart Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	with Unstable Angina	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic RENAL Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Marcos B. Galicia Jr, MD
29c. LICENSE NUMBER: D15698
29d. DATE SIGNED (Month, Day, Year): 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARCOS B. GALICIA, JR. M.D.
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23592

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KATHERINE GOLDMAN (KATHERINE GOLDMAN)
2. DATE OF DEATH — MONTH: AUG. DAY: 25 YEAR: 89
3. TIME OF DEATH: 2:06 A.M.
4. SOCIAL SECURITY NUMBER: 212-09-3687
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/09/14
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL of BALTIMORE
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3647 LANGREHR Road
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): BENJAMIN KLATZKIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNY EPHRAIM
19a. INFORMANT'S NAME (Type/Print): MR. AARON GOLDMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3647 LANGREHR RD. BALTO.,MD 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HAR ZION TIFERETH ISRAEL
20c. LOCATION — City or Town, State: ROSEDALE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Levin
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS,. INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	RUPTURED VISCUS	2 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	SEVERE END STAGE COPD	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	VENTRAL HERNIA	
DUE TO (OR AS A CONSEQUENCE OF):		
d.	GANGRENE OF ABD. WALL	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MULTIPLE OSTEOPATHIC / PATHOLOGIC FX OF SPINE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: JOHNS HOPKINS HOSPITALS Paul D. MANOUKIAN M.D. M.P.H.
29c. LICENSE NUMBER: #16245 SINAI
29d. DATE SIGNED (Month, Day, Year): 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL D. MANOUKIAN M.D. M.P.H. 2803 ST. PAUL ST., BALTO. MD. 21218
31. DATE FILED (Month, Day, Year): AUG 31 1989 / AUG 25 89
32. REGISTRAR'S SIGNATURE: John Barthauer

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23593
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Gray				2. DATE OF DEATH (Month, Day, Year): 8-23-89	3. TIME OF DEATH: 9:49 PM
4. SOCIAL SECURITY NUMBER: 213-76- 5894	5. SEX: XX M 2 F	6. AGE (In yrs. last birthday): 29 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-11-59	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1465 N. Carey Street			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: baltimore			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
10e. STREET AND NUMBER: 2431 Lauretta Avenue			10f. ZIP CODE: 21223		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook		16b. KIND OF BUSINESS/INDUSTRY: Food	
17. FATHER'S NAME (First, Middle, Last): Wayne Watt			18. MOTHER'S NAME (First, Middle, Maiden Surname): Sylvia Gray		
19a. INFORMANT'S NAME (Type/Print): Gracie Overton		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2431 Lauretta Avenue 21223			
20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastview Memorial		20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derrick C. Jones		22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones F.H. 4611 Park Heights Avenue			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Narcotic intoxication	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 Residence 6 XX Other (Specify) Friends residence

27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 XX Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 8-23-89

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 YES X NO

28d. DESCRIBE HOW INJURY OCCURED: Unknown

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FRIENDS HOUSE

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1465 N. Carey Street,Balto.MD

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): 8-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year): AUG 31 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23594

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anthony Green				2. DATE OF DEATH (Month, Day, Year): August 14 1989	3. TIME OF DEATH: 3:29 P.M.
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 2 / MIN. 24	7. DATE OF BIRTH (Month, Day, Year): 8-14-89	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Talbot	10c. CITY, TOWN OR LOCATION: Trappe	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: Charlie Will Canning Co. Inadoff Rd.		10f. ZIP CODE: 21673	10g. CITIZEN OF WHAT COUNTRY?: US.

11. MARITAL STATUS: X 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Anthony Gary Blackwell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Linda Marie Green	
19a. INFORMANT'S NAME (Type/Print): Linda Marie Green		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Charlie Will Canning Co. Landoff Rd. ,Trappe Md. 21673	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in-state removal	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):	20c. LOCATION — City or Town, State:	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald D Wade		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Prematurity - (16-week fetus)	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Premature labor & Delivery	hours
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Reinhardt Sahmel M.D.	29c. LICENSE NUMBER: D34633	29d. DATE SIGNED (Month, Day, Year): ▶ 8/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Reinhardt Sahmel M.D. 219 S. Washington STr. Easton Md. 21601

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Taylor-Tyndall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23595 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clarence Leo HAWKINS		2. DATE OF DEATH (Month, Day, Year): August 26, 1989	3. TIME OF DEATH: 5:20A M
4. SOCIAL SECURITY NUMBER: 219-76-1137	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/18/23
8. BIRTHPLACE (State or Foreign Country): Md.			
9a. FACILITY NAME (If not institution, give street and number): AMI DOCTORS" HOSPITAL OF P.G. CO.	9b. CITY, TOWN OR LOCATION OF DEATH: LANHAM	9c. COUNTY OF DEATH: PRINCE GEORGE'S	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: New Carrollton	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6441 Fairbanks St.	10f. ZIP CODE: 20784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1st; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Albert Hawkins	18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie Ponger		
19a. INFORMANT'S NAME (Type/Print): Nicholas E. Hawkins	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9104 Varnum St., Lanham, Md. 20706		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Mem. Park 9/1/89	20c. LOCATION — City or Town, State: Landover, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barry M. Pratt	22. NAME AND ADDRESS OF FACILITY: H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest 2° to Probable Aspiration

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① SR Septic Shock
② Hypothermia
③ Urosepsis
④ Hypotension
⑤ Seizure Disorder
⑥ Mental Retardation

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: MD 20989	29d. DATE SIGNED (Month, Day, Year): 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AMI Doctor's Hosp. of P.G., Lanham, Md.		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23596
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Arthur Lawrence Hux, Jr Arthur Lawrence HUX			2. DATE OF DEATH (Month, Day, Year) 8-30-89 8 - 30 - 89	3. TIME OF DEATH 8 55 P. M
4. SOCIAL SECURITY NUMBER 213-20-7550	5. SEX 1 X M 2 ☐ F	6. AGE (In yrs. last birthday) 64 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-28-24	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) 2705 Brinkleigh Drive 21043			9b. CITY, TOWN OR LOCATION OF DEATH Ellicott City		9c. COUNTY OF DEATH Howard

RESIDENCE OF DECEDENT

10a. STATE MD	10b. COUNTY Howard	10c. CITY, TOWN OR LOCATION Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER 2705 Brinkleigh Drive		10f. ZIP CODE 21043	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronic Tech.	16b. KIND OF BUSINESS/INDUSTRY Westinghouse	
17. FATHER'S NAME (First, Middle, Last) Arthur Lawrence Hux, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Goodrich	
19a. INFORMANT'S NAME (Type/Print) Josephine A. Hux		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 Brinkleigh Dr. Ellicott City, MD 21043	
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc.	20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ George E. MacNabb		22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Road, Balto., MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery thrombosis DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Thomas R. Herbert, M.D. Deputy Medical Examiner	29c. LICENSE NUMBER D-5002	29d. DATE SIGNED (Month, Day, Year) ▶ 8-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas F. Herbert, M.D. 3545 Ellicott City, MD 21043		
31. DATE FILED (Month, Day, Year) AUG 31 1989	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

OHMH-16 Rev 1/89

89-23597

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23597

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHANER C. HALDEMAN			2. DATE OF DEATH (Month, Day, Year): August 29 1989	3. TIME OF DEATH: 1.05 AM M
4. SOCIAL SECURITY NUMBER: 168.12.2187	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct 2, 1902	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE	9c. COUNTY OF DEATH: A.A. COUNTY	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Millersville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1004 Oakdale Circle		10f. ZIP CODE: 21108	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): NA	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: Stone Quarry	
17. FATHER'S NAME (First, Middle, Last): Daniel C. Haldeman		16. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Kring	
19a. INFORMANT'S NAME (Type/Print): Irma Houck	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Matthews Lutheran Cemetery	20c. LOCATION — City or Town, State: Chester Springs, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Avenue S.W., Glen Burnie, Md. 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cancer of the prostate	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD depression

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [/] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [/] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D8381	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES J. BENJAMIN, M.D. 653 OLD MILL ROAD MILLERSVILLE, MARYLAND 21108		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randell	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23598
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DELLA (DELLA) HERMAN (HERMAN)			2. DATE OF DEATH (Month / Day / Year): 8 / 23 / 89	3. TIME OF DEATH: 1145 AM
4. SOCIAL SECURITY NUMBER: 212-01-5638	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 7.12.98	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6314 GREENSPRING AVE., APT. 104		10f. ZIP CODE: 21209	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced (XXX)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: AT HOME	
17. FATHER'S NAME (First, Middle, Last): MAX GOLDBERG		18. MOTHER'S NAME (First, Middle, Maiden Surname): ESTHER MITNICK	
19a. INFORMANT'S NAME (Type/Print): MRS. ELAINE LENET		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 GRISTMILL CT., APT. 201 BALTO.,MD 21208	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW	20c. LOCATION — City or Town, State: REISTERSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sol Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	0 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ASCVD, HTN, PVD, GLAUCOMA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD	29c. LICENSE NUMBER: D37333	29d. DATE SIGNED (Month, Day, Year) ▶ 8.23.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI MD BCGH, RANDALLSTOWN MD 21133		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23599

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sharlef R. Harris (SHIRLEY R. HARRIS)
2. DATE OF DEATH: MONTH 08 DAY 23 YEAR 89
3. TIME OF DEATH: 559P M
4. SOCIAL SECURITY NUMBER: 213053562
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/22/13
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTO
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2816 Smith Avenue
10f. ZIP CODE: 21209
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): ABRAHAM ORENSTEIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE SILVER
19a. INFORMANT'S NAME (Type/Print): MR. JOSEPH ORENSTEIN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2816 SMITH AVE. BALTO., MD 21209
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): RODFE ZEDEK
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Lewis
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Pulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebro Vascular Accident - Subarachnoid Hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Complications of Sepsis from pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8/13/89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: intern
29d. DATE SIGNED (Month, Day, Year): 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOEL H HASSMAN 640 HARVEY ST BALTO MD 21230
31. DATE FILED (Month, Day, Year): AUG 31 1989 — 8/23/89
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Jones -SR Earl. C.

89 23600

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Earl C. Jones Sr.			2. DATE OF DEATH (Month, Day, Year): 8 / 27 / 89	3. TIME OF DEATH: 7:36 PM
4. SOCIAL SECURITY NUMBER: 220-14-1729	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/01/27	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1318 WINDEMERE AVENUE		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FIRE DEPARTMENT	16b. KIND OF BUSINESS/INDUSTRY: RETIRED	
17. FATHER'S NAME (First, Middle, Last): JOHN JONES	18. MOTHER'S NAME (First, Middle, Maiden Surname): MAUDE CARTER		
19a. INFORMANT'S NAME (Type/Print): DENITA V. JOHNSON	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7015 LOCHLAN CIRCLE APT C/BALTIMORE, MD 21239		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM	20c. LOCATION — City or Town, State: OWINGS MILLS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner	22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute pulmonary Edema	
DUE TO (OR AS A CONSEQUENCE OF): b.	probable acute myocardial infarction	1 hr 35 min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Hypertension.
Foot ulcer.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Adnan Sunji MD (RESIDENT III)	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): ▶ 8/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ADNAN A. SUNJI Union Memorial Hospital (201) E university Prkway. Baltimore, MD 21218.		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE:	

OHMH-16 Rev 1/89

ITEM #10A FILM #G 654 8/31/89- PER: F. H. J.A.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23601 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER L. JOHNSON				2. DATE OF DEATH: MONTH 8 DAY 29 YEAR 89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-10-1765	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6/12/11	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): COMMUNITY CARE NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. NO NUMBER AND STREET: ~~2502~~ 2503 VIOLET AVENUE APT. 711 SOUTH		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AMERICAN SMETING REF. CO	16b. KIND OF BUSINESS/INDUSTRY: RETIRED	
17. FATHER'S NAME (First, Middle, Last): WILLIAM JOHNSON		18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE THORNTON	
19a. INFORMANT'S NAME (Type/Print): GEORGIA I. JOHNSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2503 VIOLET AVE. APT. 711 S/BALTIMORE, MD 21215	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Carcinoma Lung.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
[X] 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[ ] 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D25044	29d. DATE SIGNED (Month, Day, Year): ▶ 8/2
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M Bowman		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR CLARA JACKSON

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23602 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARA - JACKSON

2. DATE OF DEATH (Month, Day, Year): AUG 27 1989

3. TIME OF DEATH: 0200A M

4. SOCIAL SECURITY NUMBER: 212-26-2229

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 71 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): JUNE 22, 1918

8. BIRTHPLACE (State or Foreign Country): TENN.

9a. FACILITY NAME (If not institution, give street and number): 605 EAST RIDGEVILLE BLVD.

9b. CITY, TOWN OR LOCATION OF DEATH: MT. AIRY

9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: MD.

10b. COUNTY: CARROLL

10c. CITY, TOWN OR LOCATION: MT. AIRY

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 605 EAST RIDGEVILLE BLVD.

10f. ZIP CODE: 21771

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+): -

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NURSING HOME OWNER

16b. KIND OF BUSINESS/INDUSTRY: NURSING HOME

17. FATHER'S NAME (First, Middle, Last): JOHN JEFFERSON

18. MOTHER'S NAME (First, Middle, Maiden Surname): BATCHIE GREENE

19a. INFORMANT'S NAME (Type/Print): JOAN A. HALL

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 701 S. MAIN ST. MT. AIRY, MD. 21771

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LAYTONSVILLE CEMETERY

20c. LOCATION — City or Town, State: LAYTONSVILLE, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Muriel H. Barber

22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME, 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIOSCLEROTIC CARDIOVASCULAR DIS 2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel I. Welliver MD

29c. LICENSE NUMBER: D 11496

29d. DATE SIGNED (Month, Day, Year): 9/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL I. WELLIVER MD. WESTMINSTER MD

31. DATE FILED (Month, Day, Year): AUG 31 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23603

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nina Kerney
2. DATE OF DEATH — MONTH DAY YEAR: 08-29-1989
3. TIME OF DEATH: 10 40 PM
4. SOCIAL SECURITY NUMBER: 214-10-1301
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 09-04-12
8. BIRTHPLACE (State or Foreign Country): Bentonville, Va
9a. FACILITY NAME (If not institution, give street and number): Inns of Evergreen - Central
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: ? Taullula Ave
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Weaver in Cotton Mill
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): William Curry
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Boyer
19a. INFORMANT'S NAME (Type/Print): Pauline Taylor
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8130 Bradshaw Rd. Bradshaw Md. 21021
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn
20c. LOCATION — City or Town, State: Balto, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Walter F Dabrowski
22. NAME AND ADDRESS OF FACILITY: 1005 Dundalk Avenue Balto, Md 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD — DUE TO (OR AS A CONSEQUENCE OF): — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. OUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Old CVA (h) Pemphigus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D 10268
29d. DATE SIGNED (Month, Day, Year): ▶ 08-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD TYSON, M.D. 934 W. North Ave Balto MD 21217-3992

31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23604 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS B. KOHN, II -LOUIS B. KOHN II					2. DATE OF DEATH (Month, Day, Year): 8 26 89	3. TIME OF DEATH: 2:30A M
4. SOCIAL SECURITY NUMBER: 219-01-6244	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2/16/17	8. BIRTHPLACE (State or Foreign Country): MD BALTIMORE
9a. FACILITY NAME (If not institution, give street and number): KESWICK NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 2410 STONE MILL RD.		10f. ZIP CODE: 21208	10g. CITIZEN OF WHAT COUNTRY? U S A

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MERCHANT	16b. KIND OF BUSINESS/INDUSTRY: RETAIL

17. FATHER'S NAME (First, Middle, Last): IRVING KOHN	18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSALIE G. GOLDSTEIN
19a. INFORMANT'S NAME (Type/Print): MRS. JOSEPHINE KOHN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2410 STONE MILL RD. BALTO., MD. (21208)

20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY	20c. LOCATION — City or Town, State: BALTO., MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sydney L. Stollman	22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction — 3days

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. arteriosclerotic heart disease

DUE TO (OR AS A CONSEQUENCE OF):

c. cerebral atherosclerosis

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E. Hunter Wilson Jr.	29c. LICENSE NUMBER: D12487	29d. DATE SIGNED (Month, Day, Year) ▶ 8.26.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. HUNTER WILSON 101 W. READ ST. BALTO, MD (21201)

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23605 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna R. Kelly
2. DATE OF DEATH: Month 8, Day 29, Year 89
3. TIME OF DEATH: 11 04 A M
4. SOCIAL SECURITY NUMBER: 216-46-0511
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/19/1896
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Rockville Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Wheaton
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12817 Holdridge Road
10f. ZIP CODE: 20906
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own home
17. FATHER'S NAME (First, Middle, Last): Edwin H. Roussey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah G. Knight
19a. INFORMANT'S NAME (Type/Print): Virginia Wilson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12817 Holdridge Road Wheaton, MD 20906
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Darlington Cemetery
20c. LOCATION — City or Town, State: Darlington, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary L Hawkins
22. NAME AND ADDRESS OF FACILITY: Harkins Funeral Home, Inc. Delta, PA

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Irreversible sepsis	2 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Recurrent Urinary tract infection	4 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Carcinoma, Right breast

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James E Wilson M.D.
29c. LICENSE NUMBER: D23392
29d. DATE SIGNED (Month, Day, Year): 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James E. Wilson, JR, M.D., 11125 Rockville Pike, Ste 103, Rockville, Md. 20852
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23606
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JIM Y. KIM			2. DATE OF DEATH: MONTH 8 DAY 29 YEAR 89	3. TIME OF DEATH: 12:30 p M
4. SOCIAL SECURITY NUMBER: 486-82-2813	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-19-1896	8. BIRTHPLACE (State or Foreign Country): South Korea

9a. FACILITY NAME (If not institution, give street and number): Inns of Evergreen N.W.	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Balto.City

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: - -	10c. CITY, TOWN OR LOCATION: Baltimore, Md.	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6203 Winner Ave. Baltimore	10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY? Korea

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Korean Oriental

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Presbyterian Minster	16b. KIND OF BUSINESS/INDUSTRY: Minster	
17. FATNER'S NAME (First, Middle, Last): Jin Young Kim	18. MOTHER'S NAME (First, Middle, Maiden Surname): Seong Nyo Lee		
19a. INFORMANT'S NAME (Type/Print): Yong Kim (Son)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6203 Winner Ave.Baltimore,Md. 21215		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Cremetory	20c. LOCATION — City or Town, State: SIlver Spring,Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roland P. Steele Jr	22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, Md. 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Presumed acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):	10 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Deborah Morris MD	29c. LICENSE NUMBER: D31364	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Deborah Morris MD 10219 So. Dolfield Rd, Owings Mills, MD 21117		
31. DATE FILED (Month, Day, Year): AUG 01 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Mendez	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23607
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRY LAZARUS				2. DATE OF DEATH (Month, Day, Year): AUGUST 26, 1989	3. TIME OF DEATH: 6:42 A M
4. SOCIAL SECURITY NUMBER: 217-38-5347	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JUNE 1, 1901	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 4103 FORDS LANE 21215			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 3809 CLARKS LANE, APT. 304		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ATTORNEY	16b. KIND OF BUSINESS/INDUSTRY: AT LAW
17. FATHER'S NAME (First, Middle, Last): SAMUEL LAZARUS		18. MOTHER'S NAME (First, Middle, Maiden Surname): JENNIE SCHRAGE	
19a. INFORMANT'S NAME (Type/Print): MRS. SHIRLEY S. LAZARUS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3809 CLARKS LANE, APT. 304 BALTO., MD 21215	
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): AITZ CHAIM CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellsworth Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myocardial infarction	5 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Generalized arteriosclerosis — DUE TO (OR AS A CONSEQUENCE OF):	several months
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d. — DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Convalescent Home	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Seymour H. Rubin MD	29c. LICENSE NUMBER: D10187	29d. DATE SIGNED (Month, Day, Year) ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SEYMOUR H. RUBIN, MD 7111 PARK HEIGHTS AVE BALTIMORE MD 21215		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 23608

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MYLES, TARSHA			2. DATE OF DEATH (Month, Day, Year): 08 27 89	3. TIME OF DEATH: 0445 M
4. SOCIAL SECURITY NUMBER: NONE	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 1 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06-02-88	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY OF MD. 22 SOUTH Greene St.		9b. CITY, TOWN OR LOCATION OF DEATH: Balt, MD.		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 929 North Hill Road ST		10f. ZIP CODE: 21218.		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant		16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): Maurice Myles			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Foster.	
19a. INFORMANT'S NAME (Type/Print): Debbie Foster.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2339 N. Calvert St. / Balto. MD #18.		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT Zion Cemetery		20c. LOCATION — City or Town, State: Lansdowne, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warren		22. NAME AND ADDRESS OF FACILITY: WM. C. March F/H 1101 E. North Ave		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio respiratory arrest.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. inoperable heart disease.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. likely overwhelming sepsis.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic lung disease.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] chief resident	29c. LICENSE NUMBER: D36137	29d. DATE SIGNED (Month, Day, Year) ▶ 8/27/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NW 550 UMH 22 South Greene ST Balt MD 21202. Pediatrics

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23609
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mable (Mabel) Geneva Murdock
2. DATE OF DEATH (Month, Day, Year): 08 26 89
3. TIME OF DEATH: 2:45 PM
4. SOCIAL SECURITY NUMBER: 220-18-6682
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-20-18
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2928 Round Road
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS OECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Eugene Holly
16. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Holly
19a. INFORMANT'S NAME (Type/Print): Fraun Murdock
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2928 Round Road Balto Md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet
20c. LOCATION — City or Town, State: Owings Mills Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lola March
22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PULMONARY EMBOLI	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSPITAL
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gerard Mullin MD
29c. LICENSE NUMBER: D37257
29d. DATE SIGNED (Month, Day, Year): ▶ 08/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GERARD MULLIN MD LIBERTY MEDICAL CENTER
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23610

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rose P. Mitchell
2. DATE OF DEATH: MONTH 8 DAY 29 YEAR 89
3. TIME OF DEATH: 7:20 PM
4. SOCIAL SECURITY NUMBER: 184 18 5555
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 04 05 22
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Mercy Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1407 Broening Highway
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife
16b. KIND OF BUSINESS/INDUSTRY: home
17. FATHER'S NAME (First, Middle, Last): Pasquale Yacobet
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Gentile
19a. INFORMANT'S NAME (Type/Print): Ruth Miller
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1421 Bonsal St. Baltimore, Md. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St Stanislaus
20c. LOCATION — City or Town, State: Baltimore, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Walter F Dabrowski
22. NAME AND ADDRESS OF FACILITY: 1005 Dundalk Avenue. Balto, Md 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory arrest secondary to squamous cell carcinoma — ~4 months
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastases of primary tumor to liver & bone of lung (Left) — ~1 month
DUE TO (OR AS A CONSEQUENCE OF):
c. Post obstructive pneumonia — ~4 months
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Persistent vomiting of unknown etiology

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8.29.89
28b. TIME OF INJURY: 1920 PM
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: RESPIRATORY ARREST
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 301 St Paul St. Baltimore, MD
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donald Thompson M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 8.29.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald Thompson, M.D. 301 St Paul St. Baltimore, MD 21202
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23611

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna M. MENCHEY			2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: 4:45a M
4. SOCIAL SECURITY NUMBER: 220-14-9882	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-9-1898	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE 721 S. PORT STREET	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 721 S. PORT STREET		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 YEARS; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): THOMAS TRAUTFELTER		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET HERZIG	
19a. INFORMANT'S NAME (Type/Print): MRS. GLORIA BLAIR		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 117 MD LINE 21105	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAKLAWN CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Konrad L. Kaczorowski		22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. 21224	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Severe Dehydration	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Severe Hyponairemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Urosepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Hypotension	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile Dementia, venous insufficiency, cardio vascular accident with right hemiplegia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: B. Oppong (HOUSE OFFICER)	29c. LICENSE NUMBER: n/a	29d. DATE SIGNED (Month, Day, Year): ▶ 8-27-89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. OPPONG FSH 9000 Franklin Square Dr. 21237			
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall		

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23612 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THERESA MECHNIEWICZ

2. DATE OF DEATH (Month, Day, Year): 08-30-89

3. TIME OF DEATH:

4. SOCIAL SECURITY NUMBER: 212-05-6925D

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 90 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 8-24-1899

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 509 S. GLOVER STREET

10f. ZIP CODE: 21224

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): JOSEPH BRZEZINSKI

18. MOTHER'S NAME (First, Middle, Maiden Surname): SOPHIE KOSINSKI

19a. INFORMANT'S NAME (Type/Print): MR. HENRY JANCEWSKI

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7210 RIVER DRIVE 21219

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREENMOUNT CEM.

20c. LOCATION — City or Town, State: BALTO. CITY

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Konrad K. Kaczorowski

22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME
2525 FLEET STREET BALTO. MD. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Diabetes

DUE TO (OR AS A CONSEQUENCE OF):

c. hypertension

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Lehs M.D

29c. LICENSE NUMBER: D-27921

29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3411 Bank St Balto.

31. DATE FILED (Month, Day, Year): AUG 31 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23613 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TONYA AKA TANYA MCLAUGHLIN		2. DATE OF DEATH: MONTH AUGUST DAY 26, YEAR 1989	3. TIME OF DEATH: 9:55 p M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 16 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-13-72 — 8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4011 Annellen Road	10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Joseph McLaughlin		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Quillens	
19a. INFORMANT'S NAME (Type/Print): Mary McLaughlin	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4011 Annellen Road, Balto., MD 21215		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	20c. LOCATION — City or Town, State: Baltimore Co., MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home, 2222-26 West North Avenue, Balto., MD 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BRAIN STEM HERNIATION	30 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Left-sided cerebrovascular accident	2 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Paradoxical embolism.	2 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ebstein's Anomaly
ASD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Aitken MD Pediatric Resident	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mary E Aitken Johns Hopkins Hospital Baltimore MD		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23614 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B 2

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leon Moore		2. DATE OF DEATH: Month 8, Day 28, Year 89	3. TIME OF DEATH: 7:58PM M
4. SOCIAL SECURITY NUMBER: 217-68-0023	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 31 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 2/17/58
8. BIRTHPLACE (State or Foreign Country): WASH., D.C.			
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1511 N. STRICKER STREET		10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): JOHNNIE L. MOORE		18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN GARDNER	
19a. INFORMANT'S NAME (Type/Print): MARY CARLOS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 SUNMAR COURT: BALTO., MD 21207		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY	20c. LOCATION — City or Town, State: CATONSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett	22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic intravenous drug abuse

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23615 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George C. Miller					2. DATE OF DEATH (Month / Day / Year): 8 / 30 / 89	3. TIME OF DEATH: 10:25 A M
4. SOCIAL SECURITY NUMBER: 213-07-8526	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07 15 1900	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City			9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT						
10a. STATE: MARYLAND	10b. COUNTY:		10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3923 ROLAND AVENUE			10f. ZIP CODE: 21211			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4TH; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PLASTERER			16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL
17. FATHER'S NAME (First, Middle, Last): CASPER MILLER			18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE (?)			
19a. INFORMANT'S NAME (Type/Print): RICHARD MILLER			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3236 SHARON ROAD, JARRETTSVILLE, MD. 21084			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LAKEVIEW MEMORIAL PARK			20c. LOCATION — City or Town, State: SYKESVILLE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz, Jr.			22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. cardiomyopathy - etiol. undetermined.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure, urinary retention, possible viral pneumonitis.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
NA	NA M	NA	NA

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Nicholas J. Kohlerman MD PG43	D37606	▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Nicholas J. Kohlerman, M.D. Union Memorial Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23616
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NELSON MAGRAM		2. DATE OF DEATH: MONTH 08 DAY 23 YEAR 89	3. TIME OF DEATH: 6 40 A M
4. SOCIAL SECURITY NUMBER: 215-07-6244	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09/05/12
8. BIRTHPLACE (State or Foreign Country): LATVIA			
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6511 GLENWICK CT.	10f. ZIP CODE: 21209	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AGENT	16b. KIND OF BUSINESS/INDUSTRY: IRS
17. FATHER'S NAME (First, Middle, Last): YEHUDA SHALOM MAGRAM		18. MOTHER'S NAME (First, Middle, Maiden Surname): EVA SAYE	
19a. INFORMANT'S NAME (Type/Print): MRS. EMILY MAGRAM		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6511 GLENWICK CT. BALTO., MD 21209	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory srrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. POSSIBLE MI	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. GI BLEED	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. METASTATIC CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL T. WITKOWSKI, M.D. SINAI HOSPITAL OF BALTIMORE, MD.

31. DATE FILED (Month, Day, Year): AUG 31 1989

32. REGISTRAR'S SIGNATURE: [signature]

ONMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23617
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Daniel L. Mays		2. DATE OF DEATH (Month, Day, Year): 8-8-89	3. TIME OF DEATH: 9:56AM M
4. SOCIAL SECURITY NUMBER: 577-16-0988	5. SEX: 1 [X] M 2 [ ] F	5. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2/4/08
8. BIRTHPLACE (State or Foreign Country)			
9a. FACILITY NAME (If not institution, give street and number): 4201 Pennington Avenue	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT			
10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 4201 PENNINGTON AVE. - ROOM 338		10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: -	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: -	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): - College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RET. ELEVATOR OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: -	
17. FATHER'S NAME (First, Middle, Last): -		18. MOTHER'S NAME (First, Middle, Maiden Surname): -	
19a. INFORMANT'S NAME (Type/Print): -	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): -		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES [X] NO — INSPECTION	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-8-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,Maryland 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23618 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Charles	Wayne	Miller, Jr	8-28-89	3:10PM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
216-02-3184	1 X M 2 ☐ F	23 YRS.			NOV. 18, 1965	England

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
4011 White Avenue	Baltimore City	City

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	City	Baltimore	1 X YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4011 White Ave.	21206	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 X NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
11		Gas Station Attendant	Crown Co.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles Wayne Miller, Sr.	Joanne Langis

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joanne Miller	6191 Northwood Drive, Baltimore, Md. 21212

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Green Mount Crematory 8-30-89	Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Wallace S. Brodbeck Sr.	Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hanging	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES X NO	1 ☐ YES X NO
INSPECTION	

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
X YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	8-28-89	M	1 ☐ YES X NO	Subject hanged self
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	Home			4011 White Avenue, Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mario F. Golle Jr. M.D.	OCME	▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Mario F. Golle, Jr., M.D.	111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Julia Davidson-Randall

OHMH-18 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23619

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Maude Hyers Maude Myers

2. DATE OF DEATH (Month, Day, Year): August 25, 1989

3. TIME OF DEATH: 5:30 P M

4. SOCIAL SECURITY NUMBER: 216 14 1816

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (If yrs. last birthday): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): July 19, ~~1902~~ 1902

8. BIRTHPLACE (State or Foreign Country): Balto. ~~xxxx~~ Co.

9a. FACILITY NAME (If not institution, give street and number): Forest Haven Nursing Home -Balto.Co.

9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville Md.

9c. COUNTY OF DEATH: Balto. County

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: N/A

10c. CITY, TOWN OR LOCATION: Balto. City

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2500 Ashton St, Balto., Md.

10f. ZIP CODE: 21223

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): N? A.
College (1-4 or 5+): N/A

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House Wife

16b. KIND OF BUSINESS/INDUSTRY: N/A

17. FATHER'S NAME (First, Middle, Last): John A. Anderson

18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Tillman

19a. INFORMANT'S NAME (Type/Print): Mrs. Hazel Taylor

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 53 Upmanor Rd. Balto. Md. 21229

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-28-89

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cem

20c. LOCATION — City or Town, State: Balto. Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ G. Truman Schwab

22. NAME AND ADDRESS OF FACILITY: Balto Md. 21229
5151 Balto. National Pike

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONON CANCER

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC ATRIAL FIBRILLATION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jasween Jalhain MD

29c. LICENSE NUMBER: D28595

29d. DATE SIGNED (Month, Day, Year) ▶ 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7220 PARK HEIGHTS AVE, BALTO MD 21208

31. DATE FILED (Month, Day, Year): AUG 31 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Ritz

ONMN-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23620

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris B. Matthews				2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-20-31	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: N/A	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 265 S. McCurley St.-Baltimore, Md.		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: N/A	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: N/A	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Samuel S. Ashley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Muriel E. Disney	
19a. INFORMANT'S NAME (Type/Print): Mrs. Alice Wilson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3218 Donald Dr.-Louisville, Ky. #40216	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____ 8-30-89		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ G. Truman Schwab		22. NAME AND ADDRESS OF FACILITY: 3512 Frederick Ave. Baltimore, Md. 21229	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infaretion DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. _____ DUE TO (OR AS A CONSEQUENCE OF):	
	d. _____	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Baskaran MD	29c. LICENSE NUMBER: D21649	29d. DATE SIGNED (Month, Day, Year) ▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMBANDAM BASKARAN 3455 Wilkens Ave. BALTIMORE MD 21229

31. DATE FILED (Month, Day, Year): AUG 31 1989 / 8-29-89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23621

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VERA C. NELSON			2. DATE OF DEATH (Month, Day, Year): 8 27 89	3. TIME OF DEATH: 2:15P.M. M
4. SOCIAL SECURITY NUMBER: 219-16-4385	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2/11/24	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Catonsville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 200 North Beaumont Avenue		10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: St. Agnes Hospital	
17. FATHER'S NAME (First, Middle, Last): Max Florian		18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Eichert	
19a. INFORMANT'S NAME (Type/Print): Theron S. Nelson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 N. Beaumont Ave. Catonsville, Md. 21228	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Elkridge, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie N. Shannon		22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D12967	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Shaw 5800 Edmondson Ave. Baltimore, Maryland		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23622
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 or 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris MAE Oliver			2. DATE OF DEATH (Month, Day, Year): 8-27-89	3. TIME OF DEATH: 8:06PM M
4. SOCIAL SECURITY NUMBER: 219-26-4196	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/16/39	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 3472 Spellman Road		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3472 SPELLMAN ROAD		10f. ZIP CODE: 21225	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC
17. FATHER'S NAME (First, Middle, Last): THOMAS BROWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ERMA BAILEY	
19a. INFORMANT'S NAME (Type/Print): SHEILA HUTCHINSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3472 SPELLMAN ROAD/BALTIMORE, MD 21225	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY	20c. LOCATION — City or Town, State: CATONSVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Seizure disorder and morbid obesity	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO
INSPECTION	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home ☒ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-18 Rev 1/89

89 23623

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ESTHER B. ORR		2. DATE OF DEATH (Month, Day, Year): AUG. 23, 1989	3. TIME OF DEATH: 6:05 P.M.
4. SOCIAL SECURITY NUMBER: 217-26-9860	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): APR. 10, 1898	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): BREVIN NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE DE GRACE	9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Havre de Grace	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 421 S. Union Street		10f. ZIP CODE: 21078	10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own home	
17. FATHER'S NAME (First, Middle, Last): Jerry Reed		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Coleman	
19a. INFORMANT'S NAME (Type/Print): Catherine L. Dardin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 508 Concord Apts. Perryville, MD 21903	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Nebo Cemetery	20c. LOCATION — City or Town, State: Delta, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey P. Loveridge		22. NAME AND ADDRESS OF FACILITY: Harkins Funeral Home, Inc. Delta, PA	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ARTERIOSCLEROSIS

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE
DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dante N. Monaco, MD	29c. LICENSE NUMBER: D07644	29d. DATE SIGNED (Month, Day, Year): 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANTE N. MONACO, MD Havre de Grace Md 21078		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 23624

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) CHAN PAK AKA CHAN Su PAK			2. DATE OF DEATH MONTH 8 DAY 30 YEAR 89	3. TIME OF DEATH 4:00 M
4. SOCIAL SECURITY NUMBER 216 21 2076	5. SEX 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday) 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 30, 1930
8. BIRTHPLACE (State or Foreign Country) KOREA				
9a. FACILITY NAME (If not institution, give street and number) HOMEWOOD HOSPITAL CENTER - SOUTH	9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	9c. COUNTY OF DEATH —		

RESIDENCE OF DECEDENT

10a. STATE MARYLAND	10b. COUNTY	10c. CITY, TOWN OR LOCATION BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 2000 ODELL AVE	10f. ZIP CODE 21237	10g. CITIZEN OF WHAT COUNTRY?	

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: KOREAN

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last) Mon Sun PAK	18. MOTHER'S NAME (First, Middle, Maiden Surname) CHONG SUK LEE
19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE

20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT	20c. LOCATION — City or Town, State BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature]	22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC RENAL CARCINOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P CVA

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Ambachew Worota MD	29c. LICENSE NUMBER D31905	29d. DATE SIGNED (Month, Day, Year) ▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AMBACHEW WOROTA, HOMEWOOD HOSP. CENTER

31. DATE FILED (Month, Day, Year) AUG 31 1989	32. REGISTRAR'S SIGNATURE Gilda Davidson-Randall

DHMH-18 Rev 1/89

UNKNOWN 89-139

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23625
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOZEF Pawowicz				2. DATE OF DEATH (Month, Day, Year): 8-15-89	3. TIME OF DEATH: 7:15AM M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 34 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 02-01-55	8. BIRTHPLACE (State or Foreign Country): POLAND
9a. FACILITY NAME (If not institution, give street and number): Chesapeake Bay off Queen Annes Co.			9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH: Queen Annes Co.

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY: POLAND	10c. CITY, TOWN OR LOCATION: BIELSKO - BIALO	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 34-231 SKAWICA	10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? POLAND

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 YEARS; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TOWER	16b. KIND OF BUSINESS/INDUSTRY: ROBERT GRAY TILE CO	
17. FATHER'S NAME (First, Middle, Last): STANISLAW PAWOWICZ		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIA GIERTUGA	
19a. INFORMANT'S NAME (Type/Print): MARIA PAWOWICZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): POLAND	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREENMOUNT CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, CITY
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski		22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. 21224	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Drowning	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXXXX 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify): Scene			
27. MANNER OF DEATH: 1 [ ] Natural 2 [XXX] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 9 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-12-89	28b. TIME OF INJURY: 2:00P M	28c. INJURY AT WORK? 1 [ ] YES 2 [XX] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject drowned
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Bay			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Chesapeake Bay off Queen Annes County, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-15-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 vc		
31. DATE FILED (Month, Day, Year): AUG 01 1989	32. REGISTRAR'S SIGNATURE	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23626
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Delores E Price
2. DATE OF DEATH: Month 8 Day 24 Year 89
3. TIME OF DEATH: 9 A M
4. SOCIAL SECURITY NUMBER: 212-12-2072
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-2-21
8. BIRTHPLACE (State or Foreign Country): Md

9a. FACILITY NAME (If not institution, give street and number): MFL/FSK 4900 Eastern Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Balt

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Balt.
10c. CITY, TOWN OR LOCATION: Balt
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2000 O'Dell Ave
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Wht

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): FRANK BLUEBAUGH
18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA SEGGIE

19a. INFORMANT'S NAME (Type/Print): JAMES BLUEBAUGH
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8644 OAK RD BALTO. MD 21234

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): VALE SUMMIT METH. CEM.
20c. LOCATION — City or Town, State: VALE Summit MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kacprowski
22. NAME AND ADDRESS OF FACILITY: Kacprowski F.H. 2525 FLEET ST.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Renal Failure.
DUE TO (OR AS A CONSEQUENCE OF):
b. Heart Failure / C.A.D.
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes Mellitus.
DUE TO (OR AS A CONSEQUENCE OF):
d. Myelofibrosis.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pressure Ulcer - Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: W.B. MD
29c. LICENSE NUMBER: D 04 383
29d. DATE SIGNED (Month, Day, Year) ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda PAC MFL/FSK Eastern Ave Balt, Md
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-18 Rev 1/89

Item 6 corrected per F.H. reb 9/1/89 reb

1 - FOR STATE REGISTRAR Item:28d per 9-29-89 cm

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23627 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John P. Roberts, Jr.			2. DATE OF DEATH Month: 8 Day: 27 Year: 89	3. TIME OF DEATH: 4:34PM M
4. SOCIAL SECURITY NUMBER: 217-58-5027	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): ~~89~~ 36 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 5/07/53	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 1 W. Conway Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10a. STREET AND NUMBER: ONE WEST CONWAY APT. 1209		10f. ZIP CODE: 21201	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 10th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NA	16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): JOHN P. ROBERTS, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MYRTLE HAMILTON	
19a. INFORMANT'S NAME (Type/Print): CATHY ROBERTS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 702 REEDBIRD AVENUE APT 302/BALTIMORE, MD 21225	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT ZION CEMETERY	20c. LOCATION — City or Town, State: LANSDOWNE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute pyelonephritis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Paraplegia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Remote gunshot wound of back	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 XXX Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX 4. Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 1982	28b. TIME OF INJURY: ukn. M	28c. INJURY AT WORK? 1 [ ] YES 2 XXX NO
	28d. DESCRIBE HOW INJURY OCCURED: ~~UNKNOWN~~ SUBJECT SHOT		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): UNKNOWN	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): UNKNOWN	

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Julia C. Goodin, M.D.	111 Penn Street, Baltimore, MD 21201	VC
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23628 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS RAUH			2. DATE OF DEATH (Month, Day, Year): AUGUST 28, 1989	3. TIME OF DEATH: 12:20P M
4. SOCIAL SECURITY NUMBER: 214-01-2438	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7/06/1917	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: ~~BALTIMORE~~	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 112 N. Glover St.		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Cauc.

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unk; College (1-4 or 5+): Unk.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Groundskeeper	16b. KIND OF BUSINESS/INDUSTRY: Apartments
17. FATHER'S NAME (First, Middle, Last): John Rauh		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Unknown	
19a. INFORMANT'S NAME (Type/Print): Henry Rauh		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 N. Glover St. Baltimore, Md. 21224	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory	20c. LOCATION — City or Town, State: Baltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard Dabrowski		22. NAME AND ADDRESS OF FACILITY: 2818 E. Baltimore St. B. Dabrowski & Son Baltimore, Md. 21224	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. myocardial infarction	10 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan K. Duncan MD	29c. LICENSE NUMBER: E9890	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan K. Duncan M.D. 600 N. Wolfe St. Baltimore, MD 21205

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 3 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items:23,27 per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23629

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hiawatha Roberson			2. DATE OF DEATH (Month, Day, Year): 8-18-89	3. TIME OF DEATH: 2:16PM M
4. SOCIAL SECURITY NUMBER: 245-42-3162	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 56 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 5,1932	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): 7401 Hawthorne St.		9b. CITY, TOWN OR LOCATION OF DEATH: Landover		9c. COUNTY OF DEATH: Prince Georges Co.
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Landover		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7401 Hawthorne St.		10f. ZIP CODE: 20785		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 8+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman		16b. KIND OF BUSINESS/INDUSTRY: Merchandising
17. FATHER'S NAME (First, Middle, Last): John I. Roberson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nancy Tyson		
19a. INFORMANT'S NAME (Type/Print): Selma B. Roberson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7100 Valley Park Rd.,Cap. Hgts.,Md.20743		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cheltenham Vet's.Cem.8/28/89		20c. LOCATION — City or Town, State: Cheltenham,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry N. Pratt		22. NAME AND ADDRESS OF FACILITY: H.S.Washington & Sons,Inc. 4925 Burroughs Ave.,N.E.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Julia C. Goodin, M.D.	OCME	▶ 8-19-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Julia Davidson-Kendall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23630
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alphonso Ross			2. DATE OF DEATH (Month, Day, Year): 8 27 89	3. TIME OF DEATH: 545 AM
4. SOCIAL SECURITY NUMBER: 216-38-7240	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05-06-43	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Hubaty Med Grp	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH		

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2781 The Alameda		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): George Scott		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Ross	
19a. INFORMANT'S NAME (Type/Print): Mrs. Catherine Shedrick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2781 The Alameda, Balto., MD 21218	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cem.	20c. LOCATION — City or Town, State: Balto, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home, 2222-26 West North Avenue, Baltimore, MD 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CARDIOPULMONARY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gerard Mullin	29c. LICENSE NUMBER: D37257	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GERARD MULLIN LIBERTY MEDICAL CENTER		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23631

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Morton Mayer Rosen (MORTON MAYER ROSEN)
2. DATE OF DEATH: MONTH 8 DAY 25 YEAR 89
3. TIME OF DEATH: 0800 A M
4. SOCIAL SECURITY NUMBER: 218 28 2962
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/5/31
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Deaton Hosp. & Med Ctr
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: REISTERSTOWN
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 119 ROCKRIMMON ROAD
10f. ZIP CODE: 21136
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF-EMPLOYED
16b. KIND OF BUSINESS/INDUSTRY: ELECTRICAL CONTRACTOR
17. FATHER'S NAME (First, Middle, Last): HAROLD ROSEN
18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH STEIN
19a. INFORMANT'S NAME (Type/Print): MRS. MARCIA ROSEN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 119 ROCKRIMMON RD. REISTERSTOWN, MD 21136
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BNAI ISRAEL CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Glioblastoma multiforme	1½ years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: S/p craniotomy S/p radiation S/p chemotherapy S/p burn @ arm S/p Greenfield filter placement S/p bil. inguinal hernia repairs

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy J. Kean
29c. LICENSE NUMBER: D37458
29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23632

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GILBERT RIFKIN (GILBERT RIFKIN)

2. DATE OF DEATH (Month, Day, Year): 8-25-89

3. TIME OF DEATH: 5:00 M

4. SOCIAL SECURITY NUMBER: 216-32-8072

5. SEX: 1 ☑ M 2 ☐ F

6. AGE (in yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): SEPT. 1, 1914

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION: RANDALLSTOWN

10d. INSIDE CITY LIMITS? XX YES 2 ☐ NO

10e. STREET AND NUMBER: 8903 MAPLEBROOK RD.

10f. ZIP CODE: 21133

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 8 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SHIP CHANDLER

18b. KIND OF BUSINESS/INDUSTRY: SUNDRIES

17. FATHER'S NAME (First, Middle, Last): HARRY RIFKIN

18. MOTHER'S NAME (First, Middle, Maiden Surname): EDITH UNKNOWN

19a. INFORMANT'S NAME (Type/Print): MRS. CLARA RIFKIN

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8903 MAPLEBROOK RD. RANDALLSTOWN, MD 21133

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH TFILOH

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney L. Sullman

22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRACTABLE VENTRICULAR TACHYCARDIA & FIBRILLATION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS
CONGESTIVE HEART FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Orlando B. Conaway M.D.

29c. LICENSE NUMBER: D19502

29d. DATE SIGNED (Month, Day, Year): 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ORLANDO B. CONAWAY M.D. BCGH, RANDALLSTOWN MD 21133

31. DATE FILED (Month, Day, Year): AUG 31 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23633

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jane W. Roche					2. DATE OF DEATH Month: 08 Day: 27 Year: 89		3. TIME OF DEATH: 7:20 P M
4. SOCIAL SECURITY NUMBER: 219-34-0749	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 23, 1912		8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: BALTO		
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Cockeysville			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO		
10e. STREET AND NUMBER: 7 Firefly Circle #D		10f. ZIP CODE: 21030			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Register Nurse			16b. KIND OF BUSINESS/INDUSTRY: Nursing		
17. FATHER'S NAME (First, Middle, Last): WAlter Weisbrod		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Watts					
19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia Robertson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1187 Luther Drive, Rockledge, Fla. 32955					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Prospect Hill			20c. LOCATION — City or Town, State: Towson, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson		22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd. Timonium, Md. 21093					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY METASTATIC CARCINOMA of UNKNOWN ETIOLOGY DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF):	
	c. ASCVD DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M.D.	D33215	▶ 08/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23634

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORIS S. RANDALL				2. DATE OF DEATH (Month, Day, Year): 8 2 89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 718-10-7261	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6/13/10	8. BIRTHPLACE (State or Foreign Country): WASH., D.C.
9a. FACILITY NAME (If not institution, give street and number): 917 Mastline Dr.			9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS		9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ANNAPOLIS	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 917 MASTLINE DR.		10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): HENRY STRINGER		18. MOTHER'S NAME (First, Middle, Maiden Surname)	
19a. INFORMANT'S NAME (Type/Print): M JAMES RANDALL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 254 WAYCROSS WAY, ARNOLD, MD. 21012	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randall McNair		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Vent. arrhythmia	
DUE TO (OR AS A CONSEQUENCE OF): b.	Severe CHF	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Severe Cardiomyopathy	
DUE TO (OR AS A CONSEQUENCE OF): d.	Severe ASCVD	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Norma Walsh (R. Colgan)	D24768	▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 703 Giddings ave, Annapolis, Md 21401

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Justin Davidson-Randall

DHMH-16 Rev 1/89

89 23635

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Howard Rodney Smith				2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 578-03-4216	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 98 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03/23/91	8. BIRTHPLACE (State or Foreign Country): Nebraska
9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Cntr.		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: ---	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1500 E. 35th Street		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chemist	16b. KIND OF BUSINESS/INDUSTRY: United States Food & Drug Administration
17. FATHER'S NAME (First, Middle, Last): James P. Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ettie Malvene Pattee	
19a. INFORMANT'S NAME (Type/Print): Philip R. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8207 Pleasant Plain Rd. Towson, MD 21204	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb		22. NAME AND ADDRESS OF FACILITY: Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-pulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 6 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D-17992	29d. DATE SIGNED (Month, Day, Year): ▶ 08/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Khin M. Tun, M.D. 1006 Taylor Avenue Baltimore, MD 21204

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23636

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Schweiger
2. DATE OF DEATH: Month 8 Day 28 Year 89
3. TIME OF DEATH: 9:30 P M
4. SOCIAL SECURITY NUMBER: 219329022
5. SEX: 1 X M 2 F
6. AGE (In yrs. last birthday): 51 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/10/38
8. BIRTHPLACE (State or Foreign Country)

9a. FACILITY NAME (If not institution, give street and number): Mason F. Lord Chronic Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 X YES 2 NO
10e. STREET AND NUMBER: 7405 BERKSHIRE ROAD
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO — IF YES, GIVE WAR OR DATES: KOREA
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8YEARS; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MACHINE SETTER
16b. KIND OF BUSINESS/INDUSTRY: WESTERN ELECTRIC

17. FATHER'S NAME (First, Middle, Last): JOHN W. SCHWEIGER
18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE HOMAN

19a. INFORMANT'S NAME (Type/Print): MRS. RAMONA SCHWEIGER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7405 BERKSHIRE ROAD BALTO. MD. 21224

20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART OF JESUS CEM
20c. LOCATION — City or Town, State: BALTO. CO. MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski
22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO, MD. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Basilar Artery Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia / Atelectasis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 X Nursing Home 5 Residence 6 Other (Specify)
27. MANNER OF DEATH: 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 YES 2 NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ✓ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: RBB Staff Physician
29c. LICENSE NUMBER: D28461
29d. DATE SIGNED (Month, Day, Year): ▶ 8.29.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard Bennett, MD 5200 Eastern Ave Balto. 21224
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23637
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SARAH SCHERLIS		2. DATE OF DEATH Month: 8 Day: 29 Year: 89	3. TIME OF DEATH: 453 A.M.
4. SOCIAL SECURITY NUMBER: 215-07-3935 (215-40-0336)	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 99 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/13/80	8. BIRTHPLACE (State or Foreign Country): LITHUANIA		
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7121 PARK HTS. AVE., APT. 406		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: AT HOME	
17. FATHER'S NAME (First, Middle, Last): SIMON DAVIS		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): LOUIS B. KRAUSE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3601 CLARKS LA., APT. 314 BALTO., MD 21215	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK	20c. LOCATION — City or Town, State: RANDALLSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Burton N. Levinson	22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Sepsis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Anupa Khastgir	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SINAI HOSPITAL		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Erika Davidson-Kendall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23638 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSE SCHREIBER					2. DATE OF DEATH (Month, Day, Year): AUGUST 25, 1989	3. TIME OF DEATH: 10:45 P M
4. SOCIAL SECURITY NUMBER: 059-09-5649	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JUNE 11, 1912	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): 1017 WINDSOR ROAD 21208			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT						
10a. STATE: FLORIDA	10b. COUNTY: BROWARD		10c. CITY, TOWN OR LOCATION: DEERFIELD BEACH		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 608 S.W. NATURA BLVD., APT. 301			10f. ZIP CODE: 33441		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY: AT HOME	
17. FATHER'S NAME (First, Middle, Last): SAMUEL SHENKIN			18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA HOROWITZ			
19a. INFORMANT'S NAME (Type/Print): MRS. BONNIE RICE			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1017 WINDSOR ROAD BALTO., MD 21208			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HEBREW YOUNG MENS CEMETERY		20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUHERAL SERVICE LICENSEE: ▶ Clenance Levinson			22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Respiratory Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. COLON CANCER	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO N/A	28d. DESCRIBE HOW INJURY OCCURED: N/A
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Rosenstein M.D.	D0682	▶ 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Neil B Rosenstein M.D., 550 North Broadway Balto Md

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23639
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JESSIE F. STOKES			2. DATE OF DEATH: MONTH 08 DAY 25 YEAR 89	3. TIME OF DEATH: 4:40P M
4. SOCIAL SECURITY NUMBER: 216-12-2947	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/16/15	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH's HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BEL AIR	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: 916 BALTIMORE PIKE		10f. ZIP CODE: 21014	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): HARRY MUENCH		18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE VIOLA GROVES		
19a. INFORMANT'S NAME (Type/Print): LEROY STOKES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 916 BALTIMORE PIKE, BEL AIR, MD. 21014		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. POSS. HEPATIC ENCEPHALOPATHY	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CHRONIC ANEMIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. GASTROENTESTINAL BLEED	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	28d. DESCRIBE HOW INJURY OCCURED		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D33215	29d. DATE SIGNED (Month, Day, Year): ▶ 08/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [signature]		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23640

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Steeles			2. DATE OF DEATH (Month, Day, Year): 8-18-89	3. TIME OF DEATH: 12:02PM M
4. SOCIAL SECURITY NUMBER: 219-01-3788	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 1/5/03	8. BIRTHPLACE (State or Foreign Country): VA.
9a. FACILITY NAME (If not institution, give street and number): 201 N. Broadway	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City,	9c. COUNTY OF DEATH		

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 201 N. BROADWAY - APT. 10-0		10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: -	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: -	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): - College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RET. CEMENT FINISHER	16b. KIND OF BUSINESS/INDUSTRY: -	
17. FATHER'S NAME (First, Middle, Last): -		18. MOTHER'S NAME (First, Middle, Maiden Surname): -	
19a. INFORMANT'S NAME (Type/Print): -		19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): -	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [XX] NO INSPECTION	24b. WERE AUTOPSY FINDINDS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES [XXX] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [XX] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home [XX] Residance 6 [ ] Other (Specify)		
27. MANNER OF DEATH: [XXX] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
[XXX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-19-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 2364

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANDREW R. THOMAS (Andrew R Thomas)
2. DATE OF DEATH (Month, Day, Year): 8/27/89
3. TIME OF DEATH: 4:50 PM
4. SOCIAL SECURITY NUMBER: 579 46 3815
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 53 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Mar 30, 1936
8. BIRTHPLACE (State or Foreign Country): Wash.,D.C.
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON
9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Ft. Washington
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3004 Rose Valley Drive
10f. ZIP CODE: 20744
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bus Driver
16b. KIND OF BUSINESS/INDUSTRY: Metro Transit
17. FATHER'S NAME (First, Middle, Last): ANDREW THOMAS
18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE TOLSON
19a. INFORMANT'S NAME (Type/Print): AUDREY THOMAS WIFE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 130 Kentucky Avenue, S.E. Wash.,D.C. 20003
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) — 9/1/89
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHELTENHAM VETERANS CEMETERY
20c. LOCATION — City or Town, State: CHELTENHAM,MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alex S. Pope Jr. 174
22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOME, 2617 Pennsylvania Avenue,S.E.DC 20020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Metastatic Lung Cancer	16 months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Acute Respiratory Distress due to tumor obstruction

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Harvey J Katzen MD
29c. LICENSE NUMBER: D20352
29d. DATE SIGNED (Month, Day, Year): 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HARVEY J. KATZEN MD 8926 WOODYARD RD Clinton MD 20735
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

UNKOWN 89-103

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23642

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2-5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): UNKNOWN 89-103
2. DATE OF DEATH — MONTH: 7 DAY: 13 YEAR: 89
3. TIME OF DEATH: 3:15 PM
4. SOCIAL SECURITY NUMBER: —
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): — YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): —
8. BIRTHPLACE (State or Foreign Country): —

9a. FACILITY NAME (If not institution, give street and number): Shop - 1407 Key Hwy. Pier - Rear of Fire Dept. Repair
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: —
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: —
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: —
10f. ZIP CODE: —
10g. CITIZEN OF WHAT COUNTRY: —

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): —
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): —
18. MOTHER'S NAME (First, Middle, Maiden Surname): —

19a. INFORMANT'S NAME (Type/Print): —
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): —

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Drowning	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURRED: unknown
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): harbor
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): FOUND: harbor adjacent to 1100 Key Highway East, Baltimore City, MD

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 7/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D., 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23643 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Knowle S. Watkins			2. DATE OF DEATH (Month, Day, Year): 8-28-89	3. TIME OF DEATH: 4:26AM M
4. SOCIAL SECURITY NUMBER: 220-02-8218	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 19 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-30-70	8. BIRTHPLACE (State or Foreign Country): WASH., DC
9a. FACILITY NAME (If not institution, give street and number): Prince Georges General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: PRINCE GEORGES	10c. CITY, TOWN OR LOCATION: MT. RANIER	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 4100 - 30TH STREET		10f. ZIP CODE: 20712	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED	16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): NOBLE WATKINS		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE WHITNEY WATKINS WILLIAMS	
19a. INFORMANT'S NAME (Type/Print): ANNIE WATKINS WILLIAMS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK	20c. LOCATION — City or Town, State: LANDOVER, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward J Palmer	22. NAME AND ADDRESS OF FACILITY: H.S. WASHINGTON & SONS F.H. 4925-27 · N.H. BURROUGHS AVE, NE WASH, DC 20019		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gunshot wound to the back of the chest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-28-89	28b. TIME OF INJURY: 3:45A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3600 Eastern Avenue, Washington, DC

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Julia C. Goodin, M.D.	OCME	▶ 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23644

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN J. WELSH
2. DATE OF DEATH: MONTH 8-30-89 DAY YEAR
3. TIME OF DEATH: 12:45 P M
4. SOCIAL SECURITY NUMBER: 218-05-9033
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-27-17
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Church Hospital Corporation
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 804 N. KENWOOD AVE. XXXXXXX
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Cauc.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unk. College (1-4 or 5+): Unk.
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman
16b. KIND OF BUSINESS/INDUSTRY: Dairy
17. FATHER'S NAME (First, Middle, Last): Patrick Welsh
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Fritsch
19a. INFORMANT'S NAME (Type/Print): Marian Welsh
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 N. Kenwood Ave. Baltimore, Md. 21205
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard Dabrowski Jr.
22. NAME AND ADDRESS OF FACILITY: B. Dabrowski & Son 2818 E. Baltimore St. Baltimore, Md. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory arrest — CARDIORESPRITORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Respiratory failure — RESPRIATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

c. Chronic obstruction pulmonary disease — CHRONIC OBSTRUCTION PULMONARY DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I: ARTERIOSCLORTIC CARDIOVASCULAR DISEASE

Arteriosclerotic cardiovascular disease

Abdominal aortic aneurysm — ABDOMNAL AORTIC ANORISUM

S/P TRANSACRAL RESECT OF RECTAL CARCINOMA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Chi Chen MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 8-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR CHI CHEN M.D. 100 N. BROADWAY BALTIMORE, MD. 21231
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23645

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIAN M. WISE					2. DATE OF DEATH (Month, Day, Year): 8-29-89	3. TIME OF DEATH: 8:30 a M
4. SOCIAL SECURITY NUMBER: 216-07-9471A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3-16-12	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY			9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 502 S. LAKEWOOD AVE		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YEARS; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): JOHN KULCZYNSKI		18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE SKONIECZNY	
19a. INFORMANT'S NAME (Type/Print): MR. JOSEPH WISE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 S. LAKEWOOD AVENUE BALTO. MD 21224	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY	20c. LOCATION — City or Town, State: BALTO. CITY MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski		22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. 21224	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. METASTATIC CA OF LIVER	MONTHS
	DUE TO (OR AS A CONSEQUENCE OF): METASTATIC CA, OF THE LIVER	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. R. Nazemi MD	29c. LICENSE NUMBER: CHURCH HOSP	29d. DATE SIGNED (Month, Day, Year): 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. ATAOLLAH F. NAZEMI 100 N. BROADWAY BALTIMORE, MD. 21231

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: C. Davidson-Randall

DHMH-18 Rev 1/89

89 23646

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert R. WHITE			2. DATE OF DEATH (Month / Day / Year): 8 / 30 / 89	3. TIME OF DEATH: 0130 M
4. SOCIAL SECURITY NUMBER: 214-18-0523	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/22/19	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Bon Secourse		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3801 Hillsdale Rd		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1941 - 1945	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER	16b. KIND OF BUSINESS/INDUSTRY: SCHOOL SYSTEM	
17. FATHER'S NAME (First, Middle, Last): EMANNUEL WHITE		18. MOTHER'S NAME (First, Middle, Maiden Surname): MAMIE BLAND	
19a. INFORMANT'S NAME (Type/Print): ARRITHA C. WALKER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 HILLSDALE RD. BALTO., MD. 21207	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST CEMETERY	20c. LOCATION — City or Town, State: OWINGS MILL, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy O. Dyett		22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pulmonary Embolism	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Deep Venous Thrombosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Ischemic Cardiovascular Disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
(+) HIV

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Frank A Hamilton MD	29c. LICENSE NUMBER: D08291	29d. DATE SIGNED (Month, Day, Year): ▶ 8-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank A Hamilton MD for Bon Secours Hospital, 2000 W. Baltimore St Balt, Md 21223		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23647 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FLORENCE Wexler (FLORENCE WEXLER)			2. DATE OF DEATH (Month, Day, Year): 8 24 89	3. TIME OF DEATH: 2:13 PM
4. SOCIAL SECURITY NUMBER: 162-30-5020	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/26/13	8. BIRTHPLACE (State or Foreign Country): RUSSIA
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS		9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: PENNSYLVANIA	10b. COUNTY	10c. CITY, TOWN OR LOCATION: PHILADELPHIA	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1354 FANSHAWE ST.		10f. ZIP CODE: 19111	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced XX	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO XX IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO X Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: AT HOME	
17. FATHER'S NAME (First, Middle, Last): ISADORE SHOEMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): MR. JOEL WEXLER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 857 MAGO VISTA RD. ARNOLD, MD 21012	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State XX 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. LEBANON	20c. LOCATION — City or Town, State: COLLINGDALE, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney L. Stillman		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert T Peterson MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 8-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 130 Holiday Ct Annapolis md 21401		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: [illegible] Date	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23648
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EMMA WEIS				2. DATE OF DEATH (Month, Day, Year): AUGUST 24, 1989	3. TIME OF DEATH: 1:09 A.M.
4. SOCIAL SECURITY NUMBER: 212-05-9276	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JULY 29, 1904	8. BIRTHPLACE (State or Foreign Country): ENGLAND
9a. FACILITY NAME (If not institution, give street and number): OLD COURT NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: OWINGS MILLS	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5 GREENMOUNTAIN COURT		10f. ZIP CODE: 21117	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS	16b. KIND OF BUSINESS/INDUSTRY: CLOTHING
17. FATHER'S NAME (First, Middle, Last): ABRAHAM SEIGEL		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY (UNKNOWN)	
19a. INFORMANT'S NAME (Type/Print): MRS. AUDREY BLANKFELD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1441 WESTOVER GARDENS BLVD. RICHMOND, VA 23225	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK	20c. LOCATION — City or Town, State: RANDALLSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellerslie Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC, 6010 REISTERSTOWN RD. BALTO., MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PARKINSONS DISEASE	10 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	FEVER, Septicemiana	3 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Sacral decubitus ulcers	2 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D18326	29d. DATE SIGNED (Month, Day, Year) ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 5400 old Court Road, Randallstown Md 21133		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23649

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William K. Waters			2. DATE OF DEATH (Month, Day, Year): 8 26 89	3. TIME OF DEATH: 2:15 AM
4. SOCIAL SECURITY NUMBER: 218-18-8411	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-19-1921	8. BIRTHPLACE (State or Foreign Country): Baltimore Md.
9a. FACILITY NAME (If not institution, give street and number): Clinton Med. Center		9b. CITY, TOWN OR LOCATION OF DEATH: Balt.	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 3527 Linchester Rd.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: World War No. 2	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): PHD	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Councelor	16b. KIND OF BUSINESS/INDUSTRY: Education	
17. FATHER'S NAME (First, Middle, Last): Raymond L. Waters Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Helen Daviis	
19a. INFORMANT'S NAME (Type/Print): Catherine T. Waters		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3527 Linchest Rd. 21215	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derrick C. Jones		22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones F.H. 4611 Park Heights Avenue 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Septic shock, 2° Cholecystitis & Cholangitis.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.		
DUE TO (OR AS A CONSEQUENCE OF): c.	Cirrhosis of liver	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Sepsis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D025228	29d. DATE SIGNED (Month, Day, Year): 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ASHOK AGRAWAL		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23650 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WELLANTE, ANNA
2. DATE OF DEATH — MONTH: 8 DAY: 26 YEAR: 89
3. TIME OF DEATH: 5:07 PM
4. SOCIAL SECURITY NUMBER: 220-09-5581
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10, 2, 14
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): MERCY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: [illegible]

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: [illegible]
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 301 St. Paul Place
10f. ZIP CODE: 21202
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: [illegible]
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): [illegible] — College (1-4 or 5+): [illegible]
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Rosario Wellante
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Wellante
19a. INFORMANT'S NAME (Type/Print): Rosario Wellante
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9808 Southhall Rd 21133
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery
20c. LOCATION — City or Town, State: Baltimore MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Matthew L. McLennan
22. NAME AND ADDRESS OF FACILITY: 2302 W. North Ave 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARRHYTHMIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Psychogenic polydipsia, Bipolar disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Fernando Ferro MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FERNANDO FERRO MD, 301 ST. PAUL PLACE BALTIMORE, MD 21202

31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: [illegible]

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23651 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EMANUEL - ANAGNOSTOU			2. DATE OF DEATH (Month, Day, Year): August 30, 1989	3. TIME OF DEATH: 5:30 PM M
4. SOCIAL SECURITY NUMBER: 166-34-9274	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 16, 1935	8. BIRTHPLACE (State or Foreign Country): Pa.
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4514 Valley View Avenue		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner	16b. KIND OF BUSINESS/INDUSTRY: Restaurant
17. FATHER'S NAME (First, Middle, Last): George Anagnostou		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Stavlas
19a. INFORMANT'S NAME (Type/Print): George Anagnostou		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5414 Valley View AVenue Baltimore, Maryland 21206
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greek Orthodox Cemetery 8/3/89	20c. LOCATION — City or Town, State: Woodlawn, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Gladden James F. Gladden	22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Coronary Thrombosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Hypercholesterolemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Coronary Artery Disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATN (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Boat (Fishing Outing)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8/30/1989	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Luis G. Martin, M.D. 8/31/89	29c. LICENSE NUMBER: D07687	29d. DATE SIGNED (Month, Day, Year) ▶ 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Luis G. Martin, M.D. 419 W. Redwood Street Suite 600		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23652 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM J. ANNULIS			2. DATE OF DEATH: MONTH 8 DAY 30 YEAR 89	3. TIME OF DEATH: 4:20 PM
4. SOCIAL SECURITY NUMBER: 215-05-4726	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4/28/06	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 4320 Clareway Apt. #4E		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintance Eng.	16b. KIND OF BUSINESS/INDUSTRY: Sheraton Hotels, Inc.	
17. FATHER'S NAME (First, Middle, Last): Francis Annulis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Houck	
19a. INFORMANT'S NAME (Type/Print): Regina M. Holmes	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2901 Strauss Terrace Silver Spring, Md. 20904		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon	22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic Obstructive lung disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD (CLOKEY)	29c. LICENSE NUMBER: D37093	29d. DATE SIGNED (Month, Day, Year) ▶ 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harry Kaplan MD 4940 Eastern Avenue, Baltimae, Md. 21217		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

Items:28e per ME G-657
11-17-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23653
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): (BABY) Rochelle R. Briscoe			2. DATE OF DEATH: MONTH 8-30-89 DAY YEAR	3. TIME OF DEATH: 2:31 AM M
4. SOCIAL SECURITY NUMBER: NA	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS 3 DAYS / IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 5/19/89
8. BIRTHPLACE (State or Foreign Country): MD				
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? X ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1834 ASHLAND AVENUE		10f. ZIP CODE: 21205		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INFANT		16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): DEAN BRISCOE		18. MOTHER'S NAME (First, Middle, Maiden Surname): ERAINE BURNS		
19a. INFORMANT'S NAME (Type/Print): ANNIE COVEL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1834 ASHLAND AVENUE/BALTIMORE, MD 21205		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY		20c. LOCATION — City or Town, State: CATONSVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Anne Davis		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Blunt force injuries of head, chest and abdomen	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide XX Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	26c. INJURY AT WORK?	26d. DESCRIBE HOW INJURY OCCURED
8-29-89	ukn. M	1 ☐ YES XX NO	Subject beaten

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): 1425 E Eager St ~~home~~

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 333 Lorraine Ave., Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 8-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 1 1989

32. REGISTRAR'S SIGNATURE: Gubra Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23654
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FANNIE M. BROWN
2. DATE OF DEATH (Month, Day, Year): 8 30 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-09-5152
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/14/20
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): 3800 BELLE PARK TOWERS APT 319
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3800 BELLE PARK TOWERS APT 319
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NA
16b. KIND OF BUSINESS/INDUSTRY: RETIRED
17. FATHER'S NAME (First, Middle, Last): WILLIAM DUNGER
18. MOTHER'S NAME (First, Middle, Maiden Surname): MAMIE JACKSON
19a. INFORMANT'S NAME (Type/Print): SARAH STREAMS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 225 N. DALLAS COURT/BLATIMORE, MD 21231
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): MOUNT AUBURN CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): ☒ 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: D25044
29d. DATE SIGNED (Month, Day, Year): ▶ 8/30
30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print): M Peerman
31. DATE FILED (Month, Day, Year): SEP 1 1989
32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23655

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Franklin A. Blackwell				2. DATE OF DEATH (Month, Day, Year): August 29, 1989	3. TIME OF DEATH: 1:41 aM
4. SOCIAL SECURITY NUMBER: 212-36-2540	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03/02/36	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE:	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 1713 DRUID HILL AVENUE		10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): KITCHEN HELPER		16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): COLLIN BLACKWELL		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY KNIGHT			
19a. INFORMANT'S NAME (Type/Print): FRANCES GARDNER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 DRUID HILL AVENUE/BALTIMORE, MD 21217			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT CALVARY CEMETERY		20c. LOCATION — City or Town, State: ANNE ARUNDEL CO., MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Fulminant Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HIV- Immuno-compromised Host	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jamal A. Halim		▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jamal Abdel-Halim, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Esther Davidson-Randall

DHMH-16 Rev 1/89

89 23656

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1007

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN E BROWN			2. DATE OF DEATH (Month, Day, Year): 8 28 89	3. TIME OF DEATH: 4:40 PM
4. SOCIAL SECURITY NUMBER: 216092903	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 7/22/13	8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? X YES 2 ☐ NO
10e. STREET AND NUMBER: 2810 HARFORD ROAD		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ROOFING	16b. KIND OF BUSINESS/INDUSTRY: SELF EMPLOYED	
17. FATHER'S NAME (First, Middle, Last): HOWARD BROWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): LUCY WHITE	
19a. INFORMANT'S NAME (Type/Print): GLADYS BROWN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2810 HARFORD ROAD/BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION: X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM	20c. LOCATION — City or Town, State: OWINGS MILLS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Brown		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	SEPTIC SHOCK	08/06/89
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	UROSEPSIS	to 8/28/89
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Aspiration Pneumonia	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dr M. Goldberg	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. M. Goldberg Harbor Hospital Ctr 3001 S. Hanover St. Baltimore MD.

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23657 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret H. Brady		2. DATE OF DEATH (Month, Day, Year): Aug. 29 1989	3. TIME OF DEATH: 3 AM M
4. SOCIAL SECURITY NUMBER: 218-36-2492	5. SEX: 1 ☐ M 2 ☒ F	6. BIRTHPLACE (State or Foreign Country): Texas	7. DATE OF BIRTH (Month, Day, Year): Mar. 21 95
8. AGE (In yrs. last birthday): 94 YRS.	IF UNDER 1 YEAR: MONTHS ___ DAYS ___ IF UNDER 24 HRS.: HOURS ___ MIN. ___		
9a. FACILITY NAME (If not institution, give street and number): College Manor N.H.	9b. CITY, TOWN OR LOCATION OF DEATH: Lutherville	9c. COUNTY OF DEATH: Balto.	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Lutherville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 300 W. Seminary Ave.	10f. ZIP CODE: 21093	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): James Tilden Haile	18. MOTHER'S NAME (First, Middle, Maiden Surname): Hanna Goodlet		
19a. INFORMANT'S NAME (Type/Print): Mrs. Johns Hoffman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 314 Taplow Rd., Balto., Md. 21212		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ___	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery	20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Davis III	22. NAME AND ADDRESS OF FACILITY: 4905 York Rd., balto. Md. Henry W. Jenkins & Sons Co.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic C.V. Disease, decompensated	1 mo
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Malnutrition

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Norman R. Freeman Jr.	D0 2001	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Norman Freeman 4300 N. Charles St. Apt 11G Baltimore Md

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23658 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIOLA EMMA BRADY				2. DATE OF DEATH (Month, Day, Year): 8/25/1989	3. TIME OF DEATH: 12:30 AM
4. SOCIAL SECURITY NUMBER: 484-12-4282	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3/16/1923	8. BIRTHPLACE (State or Foreign Country): Minnesota
9a. FACILITY NAME (If not institution, give street and number): 200 Fort Meade Road, Apt. 811			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 200 Fort Meade Road, Apt. #811		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NSA	16b. KIND OF BUSINESS/INDUSTRY: US Federal Government	
17. FATHER'S NAME (First, Middle, Last): Peter F. Casper		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Ludwig Casper	
19a. INFORMANT'S NAME (Type/Print): Ms. Anita A. Chilcote		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5713 Magie St., Baltimore, Maryland 21225	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. POSSIBLE MYOCARDIAL INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D24924	29d. DATE SIGNED (Month, Day, Year): ▶ 08-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGORY A COMPTON MD 3317 Cherry Lane Laurel MD 20707

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23659

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIA BATTAGLIA			2. DATE OF DEATH (Month, Day, Year): AUGUST 28, 1989	3. TIME OF DEATH: 4:15 P. M
4. SOCIAL SECURITY NUMBER: 213-74-1328	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 28, 1906	8. BIRTHPLACE (State or Foreign Country): ITALY
9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: --	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: --	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 807 COOKS LANE		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY?: ITALY

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): ANTONIO ALASCIO		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIA	
19a. INFORMANT'S NAME (Type/Print): PHILIP BATTAGLIA	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 COOKS LANE, BALTIMORE, MD. 21229		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy M. Witzke	22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute respiratory failure	
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. interstitial fibrosis/emphysema	
	OUE TO (OR AS A CONSEQUENCE OF):	
	c. -	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: syndrome inappropriate ADH

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C D Kearney MD	29c. LICENSE NUMBER: D27860	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 700 WASH BLVD BALT MD 21230 CHRISTOPHER D KEARNEY MD

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Henderson-Randall

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23660
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris Baumgart			2. DATE OF DEATH (Month, Day, Year): August 29, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214 24 5026	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 01/10/18	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1224 Susquehanna Road		9b. CITY, TOWN OR LOCATION OF DEATH: Middle River		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Middle River		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1224 Susquehanna Road		10f. ZIP CODE: 21220		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Frederick Brant		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary L. Butterworth		
19a. INFORMANT'S NAME (Type/Print): Albert F. Baumgart (son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1217 Chesapeake Ave. Baltimore Maryland 21220		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery	20c. LOCATION — City or Town, State: Baltimore County, Md		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A. 21221, 1407 Old Eastern Ave Baltimore Maryland			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chronic Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Obstructive Pulmonary Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Emphysema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Norris Horwitz MD	29c. LICENSE NUMBER: D-8225	29d. DATE SIGNED (Month, Day, Year) ▶ Aug 30, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Norris L. Horwitz, M.D.;4000 Old Court Road #203, Baltimore, MD 21208

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

89 23661

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TOMMY H. CLAY				2. DATE OF DEATH (Month, Day, Year): Aug 30 89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 065 42 8906	5. SEX: 1 ☒ M 2 ☐ F	8. AGE (If yrs. last birthday): 43 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-08-46	6. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2039 PENNSYLVANIA AVENUE		10f. ZIP CODE: 21217			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 6+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUTCHER & DRIVER		16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): ELBERT PUREFOY			18. MOTHER'S NAME (First, Middle, Maiden Surname): BEULAH CLAY		
19a. INFORMANT'S NAME (Type/Print): BEULAH CLAY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 621 N. APPLETON STREET/BALTIMORE, MD 21217			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FREDERICK DOUGLAS CEMETERY		20c. LOCATION — City or Town, State: STANTON ISLAND, NY	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. INTRA ABDOMINAL ABCESS

DUE TO (OR AS A CONSEQUENCE OF):

c. IMMUNO SUPPRESSION

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE
STATUS POST TRANSPLANT.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Curtis G. Drews MD

29c. LICENSE NUMBER: D-21420

29d. DATE SIGNED (Month, Day, Year): ▶ 31 Aug 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BON SECOURS HOSP 21223

31. DATE FILED (Month, Day, Year): SEP 1 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23662

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gertrude Conley			2. DATE OF DEATH (Month, Day, Year): 08 30 89	3. TIME OF DEATH: 10:40 AM
4. SOCIAL SECURITY NUMBER: 215-18-5416	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07/09/19	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): UMAB		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 409 S. Payson Street	10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): John H. Rasel	18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Nichols		
19a. INFORMANT'S NAME (Type/Print): Sharon DeMetro	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 908 Imperial Ct. Lansdowne, Md. 21227		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill	20c. LOCATION — City or Town, State: Brooklyn Pk. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. 21227		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Small cell Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Liver metastases	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Mediastinal Mass	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D38119	29d. DATE SIGNED (Month, Day, Year): ▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY FISHBEIN, MD 22 South Greene St Balt, MD

31. DATE FILED (Month, Day, Year): 8/~~30~~/~~89~~ 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23663
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRY J. CARROLL				2. DATE OF DEATH (Month, Day, Year): Aug. 30, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 215-07-3129A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 24, 1910	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 716 Camberley Circle, Apt. T2			9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Towson			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 716 Camberley Circle, Apt. T2		10f. ZIP CODE: 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Consultant		16b. KIND OF BUSINESS/INDUSTRY: Carroll Tree Service		
17. FATHER'S NAME (First, Middle, Last): William H. Carroll			18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosettia McCauley		
19a. INFORMANT'S NAME (Type/Print): Mary C. Carroll			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8415 Bellona Lane, Apt. 406		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery 9/1/89		20c. LOCATION — City or Town, State: Pikesville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S Brooks Jr.			22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive cardiomyopathy.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ATHEROSCLEROSIS.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A H Ghiladi MD	D-12849	▶ 8-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. H. Ghiladi, M.D. 7600 Osler Drive, Towson, Maryland 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

OHMH-16 Rev 1/89

Film G655 item 16b,20b 9-13-89 rja

89 23664

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERMA S. CALDWELL				2. DATE OF DEATH (Month, Day, Year): August 31, 1989	3. TIME OF DEATH: 5:45 A.M.
4. SOCIAL SECURITY NUMBER: 262-41-7296	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5/3/1900	8. BIRTHPLACE (State or Foreign Country): Penna.
9a. FACILITY NAME (If not institution, give street and number): Frederick Villa Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Towson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 205 East Joppa Rd. Unit 401		10f. ZIP CODE: 21204	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Reading ~~Reading~~, Pa. School System
17. FATHER'S NAME (First, Middle, Last): Edward Snyder		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Eva Graeff	
19a. INFORMANT'S NAME (Type/Print): Robert Caldwell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Charles Evans Cemetery 9/2/89	20c. LOCATION — City or Town, State: Reading, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ruth E. Ruck Sr.		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. UROSEPSIS Suspect	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. OSCAD	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (a) OSCAD (b)

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gayeydo	29c. LICENSE NUMBER: D-19528	29d. DATE SIGNED (Month, Day, Year): 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Elmo M. Gayoso, M.D. 5411 Old Frederick Road, Baltimore, MAryland 21229

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23665 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): Marcella Jones Dunlap		2. DATE OF DEATH Month: 8 Day: 31 Year: 89	3. TIME OF DEATH: 8:30 A M
4. SOCIAL SECURITY NUMBER: 218-14-8863	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-18-18
8. BIRTHPLACE (State or Foreign Country): N.C.			
9a. FACILITY NAME (If not institution, give street and number): 1720 N. Caroline St.	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH: —	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1720 N. Caroline St.	10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurses Aid	16b. KIND OF BUSINESS/INDUSTRY: Hospital	
17. FATHER'S NAME (First, Middle, Last): John C. Jones	18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Barnett		
19a. INFORMANT'S NAME (Type/Print): Cary Dunlap	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1720 N. Caroline St. Balto, Md. 21213		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): G.F. Veterans Cemetery	20c. LOCATION — City or Town, State: Owings Mills, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph J. Collick	22. NAME AND ADDRESS OF FACILITY: Collick F.H. 2431 E. Oliver St. Baltimore, Md. 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Kidney failure	~2 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic breast cancer	~17 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
☒ 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Paul Chang, MD	D16587	▶ 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Chang, MD Good Samaritan Hospital, Baltimore, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Gloria Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23666

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEO RICHARD DIXON, JR.
2. DATE OF DEATH (Month, Day, Year): 08 30 89
3. TIME OF DEATH: 113 AM M
4. SOCIAL SECURITY NUMBER: 214-44-6494
5. SEX: ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 43 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/10/45
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Pasadena
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 182 Circle Road
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouse Manager
16b. KIND OF BUSINESS/INDUSTRY: D. Myers & Sons
17. FATHER'S NAME (First, Middle, Last): Leo R. Dixon
18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan M. Mercer
19a. INFORMANT'S NAME (Type/Print): Barbara L. Dixon
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 182 Circle Road Pasadena, Maryland 21122
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakeview Memorial Gardens
20c. LOCATION — City or Town, State: Sykesville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L. [illegible]
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Septicemia, Severe hyponatremia	
DUE TO (OR AS A CONSEQUENCE OF): b.	Syndrome of SIADH, hyp CMV infection	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Severe Leucopenia	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D31322
29d. DATE SIGNED (Month, Day, Year): ▶ 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PRADEEP P. GARG, M.D. 8096 EDWIN RAYNOR BLVD., #2B PASADENA, MARYLAND 21122
31. DATE FILED (Month, Day, Year): SEP 1 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

89 23667

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Despeaux			2. DATE OF DEATH (Month - Day - Year): 08-29-89	3. TIME OF DEATH: 1045 PM
4. SOCIAL SECURITY NUMBER: 214-01-5162 A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.): 86 YRS.	7. DATE OF BIRTH (Month, Day, Year): 12-6-1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: -----		

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: -----	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3304 Grenton Ave.	10f. ZIP CODE: 21214	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Comptroller	16b. KIND OF BUSINESS/INDUSTRY: Food Corp.	
17. FATHER'S NAME (First, Middle, Last): John Despeaux	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena ---		
19a. INFORMANT'S NAME (Type/Print): Lillian A. Despeaux	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3304 Grenton Ave. Balto:Md. 21214		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery	20c. LOCATION — City or Town, State: Balto..Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hartley Miller	22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto:Md 21234		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarct	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. End Stage Renal disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
F-Khawli MD	D3505	▶ 8/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): F-Khawli Good Samaritan hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23668

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rosemary Fortune			2. DATE OF DEATH (Month, Day, Year): 8-28-89	3. TIME OF DEATH: 7:30PM M
4. SOCIAL SECURITY NUMBER: 577-86-1441	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 30 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan.1,1959	8. BIRTHPLACE (State or Foreign Country): Wash.D.C.
9a. FACILITY NAME (If not institution, give street and number): 9615 Glen Way		9b. CITY, TOWN OR LOCATION OF DEATH: Fort Washington		9c. COUNTY OF DEATH: Prince Georges Co.
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Fort Washington		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9615 Glen Way		10f. ZIP CODE: 20744		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Thrift Store		
17. FATHER'S NAME (First, Middle, Last): James Mathis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maggie Fortune		
19a. INFORMANT'S NAME (Type/Print): Maggie Fortune		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9615 GlenWay Ft.Washington,Md. 20744		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Memorial Cem.		20c. LOCATION — City or Town, State: Suitland,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ F. Bernard Hunt		22. NAME AND ADDRESS OF FACILITY: Hunt Funeral Home 2801 7th St.N.E. Wash.D.C.20017		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute narcotic intoxication	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
FOUND:8-28-89	ukn. M	1 ☐ YES 2 ☒ NO	UNKNOWN

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
FOUND: HOME	FOUND: 9615 Glen Way,Fort Washington, Prince Georges Co., MD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mario F. Golle, Jr., M.D.	OCME	▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23669 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY (Dorothea) ANNA FLEMING		2. DATE OF DEATH (Month, Day, Year): 8 30 89	3. TIME OF DEATH: 610 Am
4. SOCIAL SECURITY NUMBER: 218-03-7241	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/4/15
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Howard Co. Gen. Hosp.	9b. CITY, TOWN OR LOCATION OF DEATH: Columbia	9c. COUNTY OF DEATH: Howard	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2311 Daniel Road	10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): John L. Franz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret L. Miller	
19a. INFORMANT'S NAME (Type/Print): Walter J. Fleming	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2311 Daniels Road Ellicott City, Md. 21043		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie N. Shannon	22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	3 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebral vascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 8 ☐ Residence 5 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Luke Rao	D-17575	▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Luke RAO, M.D. 11085 Little Patuxent Parkway Columbia MD 21044

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

DNMH-16 Rev 1/86

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23670
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETTY L. FLOTO				2. DATE OF DEATH (Month, Day, Year): AUGUST 31, 1989	3. TIME OF DEATH: 0910 AM
4. SOCIAL SECURITY NUMBER: 170-30-4904	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): APRIL 7, 1938	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): 5406 ADDINGTON ROAD			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5406 ADDINGTON ROAD		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOME	
17. FATHER'S NAME (First, Middle, Last): THEODORE AWTEY		18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE OHLER	
19a. INFORMANT'S NAME (Type/Print): GEORGE E. FLOTO		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 OLD VIRGINIA ROAD, POCOMOKE CITY, MD. 21851	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK	20c. LOCATION — City or Town, State: DORSEY, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell C. Witzke	22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE MD 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AMYOTROPHIC LATERAL SCLEROSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C. Onejeme MD	29c. LICENSE NUMBER: D25459	29d. DATE SIGNED (Month, Day, Year): 8-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHINWUBA C. ONEJEME M.D. 7127 AMBASSADOR RD. BALTIMORE, MD.

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Gricha Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23671 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Norman Gladden
2. DATE OF DEATH (Month, Day, Year): 8-30-89
3. TIME OF DEATH: 3:55AM M
4. SOCIAL SECURITY NUMBER: 215-46-7545
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 42 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/05/47
8. BIRTHPLACE (State or Foreign Country): CHESTER, SC
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1711 RUTLAND AVENUE
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): JAMES GLADDEN
18. MOTHER'S NAME (First, Middle, Maiden Surname): MAGGIE NICKS
19a. INFORMANT'S NAME (Type/Print): MAGGIE GLADDEN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1711 RUTLAND AVENUE/BALTIMORE, MD 21213
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT AUBURN CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wound of head

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 [ ] ND
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8-29-89
28b. TIME OF INJURY: 2:00PM
28c. INJURY AT WORK? 1 [ ] YES 2 [X] ND
28d. DESCRIBE HOW INJURY OCCURED: Subject shot
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1711 Rutland Avenue, Baltimore City, Maryland
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 8-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 VC
31. DATE FILED (Month, Day, Year): SEP 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23672
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LORRAINE GOSSIN		2. DATE OF DEATH (Month, Day, Year): 8 28 89	3. TIME OF DEATH: 3:50 PM
4. SOCIAL SECURITY NUMBER: 415 09 0759	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (If less than last birthday): 59 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-22-29
8. BIRTHPLACE (State or Foreign Country): MISS.			

RESIDENCE OF DECEDENT

9a. FACILITY NAME (If not institution, give street and number): CARRIAGE HILL NURSING CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: MONTGOMERY	
10a. STATE: N.J.	10b. COUNTY: unknown	10c. CITY, TOWN OR LOCATION: Englewood	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 320 N.Woodland St.	10f. ZIP CODE: unknown	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: N.Y.Public Schools	
17. FATHER'S NAME (First, Middle, Last): Earnest Gossin	18. MOTHER'S NAME (First, Middle, Maiden Surname): Nannie Johnson		
19a. INFORMANT'S NAME (Type/Print): Lessie Smith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1925 Otis St.N.E. Wash.D.C. 20018		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cem.	20c. LOCATION — City or Town, State: Englewood, N.J.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ F. Bernard Hunt	22. NAME AND ADDRESS OF FACILITY: HUNT FUNERAL HOME 2801 7TH ST. N.E. WASH. D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Grand mal seizure	60 sec
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Intraventricular (Brain) hemorrhage	3 mos
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Hypertension	years.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ruth Keyess Cohen MD	29c. LICENSE NUMBER: D33159	29d. DATE SIGNED (Month, Day, Year) ▶ 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RUTH KEYESS-COHEN MD 1106 SPRING STREET SILVER SPRING MD 20910

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Gloria Davidson Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23673
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALVIN MILTON GILL				2. DATE OF DEATH (Month, Day, Year): 8 28 89	3. TIME OF DEATH: 4 p M
4. SOCIAL SECURITY NUMBER: 218-09-7322	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 25, 1920	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON		9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Fallston	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2307 Harmony Ter.		10f. ZIP CODE: 21047	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist	16b. KIND OF BUSINESS/INDUSTRY: Crown, Cork & Seal	
17. FATHER'S NAME (First, Middle, Last): George Gill		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Pierce	
19a. INFORMANT'S NAME (Type/Print): Charles Gill	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 Ferndale Ave., Glen Burnie, MD 21061		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) XXXX	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	2 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS - CRITICAL
COPD
PVD

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John P Edwards MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John P Edwards 712 Belair Rd Fallston MD 21047		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23674
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY GROSS			2. DATE OF DEATH (Month, Day, Year): August 29/89	3. TIME OF DEATH: 7:15P M
4. SOCIAL SECURITY NUMBER: 218-09-7189	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 2/14/13	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Bon Secour Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Balto city	9c. COUNTY OF DEATH		

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2503 Violet Ave South		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Major Pate	18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Butler
19a. INFORMANT'S NAME (Type/Print): William T. Hill II	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Nutmeg Knoll Ct Cockeysville, MD. 21030

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery	20c. LOCATION — City or Town, State: Balto., MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown	22. NAME AND ADDRESS OF FACILITY: William C. Brown Community F.H. 1206 W. North Ave	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Septic Shock Syndrome 2° Staph Sepsis

DUE TO (OR AS A CONSEQUENCE OF):
b. Urinary Tract infection

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Acute Renal failure 2° HTN

DUE TO (OR AS A CONSEQUENCE OF):
d. Acute Upper Gastrointestinal Bleeding

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: B Gonzales Jr M.D.	29c. LICENSE NUMBER: D18711	29d. DATE SIGNED (Month, Day, Year): ▶ Aug. 29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERNARDO J. GONZALES JR M.D. — Bon Secours Hospital 2000 W. Balto, Md. 21223		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Tomlinson-Randall	

DHMH-18 Rev 1/89

89 23675

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) BEATRICE WHITE-HUGHES		2. DATE OF DEATH (Month, Day, Year) 08 29 1989	3. TIME OF DEATH 10 AM
4. SOCIAL SECURITY NUMBER 217129182	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 73 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year) 03-06-16
8. BIRTHPLACE (State or Foreign Country) NC			
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 1202 E. MADISON STREET		10f. ZIP CODE 21202	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NA	16b. KIND OF BUSINESS/INDUSTRY RETIRED	
17. FATHER'S NAME (First, Middle, Last) THOMAS WHITE SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname) MAMIE BOWE	
19a. INFORMANT'S NAME (Type/Print) JOYCE A. HARRIS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 E. MADISON STREET/BALTIMORE, MD 21202		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY	20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Calvin L. Williams	22. NAME AND ADDRESS OF FACILITY WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.V.A. with swallowing difficulty. Dementia.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) 08-29-89	28b. TIME OF INJURY 10 AM	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER P Shah. Intern	29c. LICENSE NUMBER —	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRADIP SHAH, MD; GOOD SAMARITAN HOSPITAL, BALTIMORE.		
31. DATE FILED (Month, Day, Year) SEP 1 1989	32. REGISTRAR'S SIGNATURE Julia Davidson-Randell	

DHMH-16 Rev 1/89

UNKNOWN 89-124

89 23676

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

P

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sterling Haynes			2. DATE OF DEATH (Month, Day, Year): 8-5-89	3. TIME OF DEATH: 11:00AM M
4. SOCIAL SECURITY NUMBER: n/a	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 19 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept.21 1969	8. BIRTHPLACE (State or Foreign Country): Trinidad
9a. FACILITY NAME (If not institution, give street and number): Route 13 South, N. of Pocomoke		9b. CITY, TOWN OR LOCATION OF DEATH: ----	9c. COUNTY OF DEATH: Somerset County	
RESIDENCE OF DECEDENT				
10a. STATE: N.Y.	10b. COUNTY: --	10c. CITY, TOWN OR LOCATION: Brooklyn	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 694 Vermont St.		10f. ZIP CODE: 11207	10g. CITIZEN OF WHAT COUNTRY?: Trinidad	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): n/a	16b. KIND OF BUSINESS/INDUSTRY: n/a	
17. FATHER'S NAME (First, Middle, Last): Roland Pyle		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rita Hayes		
19a. INFORMANT'S NAME (Type/Print): Roland Pyle (father)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Movant Old Rd., Cenentille, Trinidad		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	20c. LOCATION — City or Town, State: Baltimore Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Eugene J Lastner Jr		22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Craniocerebral Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify): Scene

27. MANNER OF DEATH: 1 [ ] Natural [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 8-5-89
28b. TIME OF INJURY: 9:15AM
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Driver of auto/lost control
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 13 South, N. of Pocomoke, Somerset County, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James Kaplan

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): 8-6-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 1 1989

32. REGISTRAR'S SIGNATURE: John Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23677 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LUCILLA H. HANDS					2. DATE OF DEATH: MONTH 8 DAY 30 YEAR 89	3. TIME OF DEATH: 11 A M	
4. SOCIAL SECURITY NUMBER: 226-92-8867	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11/22/04	8. BIRTHPLACE (State or Foreign Country): Georgia	
9a. FACILITY NAME (If not institution, give street and number): Chapel Hill Conv. Center			9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore		
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Carroll		10c. CITY, TOWN OR LOCATION: Mt. Airy		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO		
10e. STREET AND NUMBER: 5312 Pommel Drive			10f. ZIP CODE: 21771		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY:		
17. FATHER'S NAME (First, Middle, Last): Hutson Lee, Jr.			18. MOTHER'S NAME (First, Middle, Maiden Surname): Selene Porcher				
19a. INFORMANT'S NAME (Type/Print): Kenneth Hands			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5312 Pommel Drive Mt. Airy, Md. 21771				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery		20c. LOCATION — City or Town, State: Pikesville, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jackie D. Shannon			22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CARDIO RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

c. ASHD

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: OLD AGE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R. RICCI MD PHYSICIAN

29c. LICENSE NUMBER: D27804

29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. RICCI MD. 3125 BALTIMORE BLVD FINKSBURG, MD

31. DATE FILED (Month, Day, Year): SEP 1 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23678 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRIEDERICKE C. HANSCH			2. DATE OF DEATH (Month, Day, Year): 8 29 89	3. TIME OF DEATH: 11:29 P M
4. SOCIAL SECURITY NUMBER: 219-26-5345	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): FEB. 1, 1902	8. BIRTHPLACE (State or Foreign Country): GERMANY
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: DUNDALK	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7802 E. COLLINGHAM DRIVE		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: GERMANY

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 TH GRADE; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): GEORG FRIES		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARETA WIESINGER	
19a. INFORMANT'S NAME (Type/Print): ERNST E. HANSCH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7802 E. COLLINGHAM DRIVE BALTIMORE, MD 21222	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 8-31-1989	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gregory E Reed		22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respirator Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ENDOMETRIAL CANCER.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D37816	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN COOPER MD. 4940 EASTERN AVE, BALTO		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23679 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Judy T. Jones				2. DATE OF DEATH (Month, Day, Year): 8-28-89	3. TIME OF DEATH: 4:59 PM
4. SOCIAL SECURITY NUMBER: 212-04-1270	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 17 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/06/71	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 704 E. CHASE STREET		10f. ZIP CODE: 21202	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NA	16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): GEORGE W. JONES, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): JOAN STEWART	
19a. INFORMANT'S NAME (Type/Print): GEORGE JONES, JR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3829-A W.STREET, SE/WASHINGTON, DC 20020	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY	20c. LOCATION — City or Town, State: ANNE ARUNDEL CO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Williams		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wound to chest with complications	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XX ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XX ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide XXX 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-19-89	28b. TIME OF INJURY: 2:15PM	28c. INJURY AT WORK? 1 ☐ YES 2 XX ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): rear of building			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 710 E. Chase Street, Baltimore, MD

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23680 REG. NO.

1841

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jay JAY ANDREW JACOBS Jacobs				2. DATE OF DEATH: MONTH 8 DAY 31 YEAR 89	3. TIME OF DEATH: 2:55 am/pm M
4. SOCIAL SECURITY NUMBER: 124-02-6213	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 24, 1915	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): University Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Ruxton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 23 Ruxview Court		10f. ZIP CODE: 21204	10g. CITIZEN OF WHAT COUNTRY?: U.S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8 +): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director Of Human Resources- Black & Decker	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Jay Allen Jacobs		18. MOTHER'S NAME (First, Middle, Maiden Surname): Vera Weik	
19a. INFORMANT'S NAME (Type/Print): Katharine H. Armentrout		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 Upnor Road, Baltimore, Md. 21212	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory 9-1-89	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL BERVICE LICENSEE: ▶ Wallace S Brooks Jr.		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. respiratory arrest	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): aortic dissection	2 days
	c. DUE TO (OR AS A CONSEQUENCE OF): coronary artery disease	2 weeks
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease
peripheral vascular disease

	24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Wagner MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ August 31, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Wagner, MD Univ of Maryland Hosp 22 S Greene St Balt MD 21201

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

89 23681

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CULLEN OLANDER KEYSER				2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89	3. TIME OF DEATH: 3:21 A M
4. SOCIAL SECURITY NUMBER: 231-48-2806	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 46 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): DEC. 23,1942	8. BIRTHPLACE (State or Foreign Country): VA

9a. FACILITY NAME (If not institution, give street and number): 5307 Nelson Avenue	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5307 Nelson Avenue		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOREMAN	16b. KIND OF BUSINESS/INDUSTRY: Septic Tank& Sewer	
17. FATHER'S NAME (First, Middle, Last): JOHN LAWS KEYSER		18. MOTHER'S NAME (First, Middle, Maiden Surname): VIVIAN GREEN	
19a. INFORMANT'S NAME (Type/Print): PATRICIA NORRIS KEYSER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route# 2 Box 204 Wicomico Church, Virginia 22579	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FIRST BAPTIST CHURCH CEMETERY	20c. LOCATION — City or Town, State: HEATHSVILLE, VA 22473
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Berry O. Waddy		22. NAME AND ADDRESS OF FACILITY: BERRY O. WADDY FUNERAL HOME P. O. BOX 165, LANCASTER, VA 22503	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Hypertensive cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street Baltimore, Md. 21201

31. DATE FILED (Month, Day, Year): SEP -1 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23682
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JANE E. KASPAR			2. DATE OF DEATH (Month, Day, Year): AUG. 28, 1989	3. TIME OF DEATH: 4:45 P M
4. SOCIAL SECURITY NUMBER: 216-16-6516	5. SEX: 1 ☐ M 2 ☒ F (XX)	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8,13,1922	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN LONG GREEN N.H.		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: DEER BIT LANE		10f. ZIP CODE: 21057		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FORM DESIGNER		16b. KIND OF BUSINESS/INDUSTRY: U.S.GOVERNMENT
17. FATHER'S NAME (First, Middle, Last): WILBUR W. ALLEN SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSI PARIE		
19a. INFORMANT'S NAME (Type/Print): WILBUR W. ALLEN JR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3903 JUNIPER RD. BALTIMORE MD. 21218		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEM. PARK		20c. LOCATION — City or Town, State: BALTIMORE MD. 21234
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R.H. Ruth		22. NAME AND ADDRESS OF FACILITY: H.W.JENKINS AND SONS CO. 4905 YORK RD. BALTO.MD. 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	2 M.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Senile Dementia	10 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. —	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: old CVA

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gregory J. Stelter MD	D25 662	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Walker & 3300 N. Calvert St Balto MD 21218

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 7 1989	Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23683 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BRAMWELL KELLY			2. DATE OF DEATH: MONTH 8 DAY 26 YEAR 89	3. TIME OF DEATH: 10:55 P M
4. SOCIAL SECURITY NUMBER: 213-32-0269	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-28-10	8. BIRTHPLACE (State or Foreign Country): Baltimore
9a. FACILITY NAME (If not institution, give street and number): St. Joseph's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3812 Juniper St.		10f. ZIP CODE: 21218		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mortgage Officer	16b. KIND OF BUSINESS/INDUSTRY: Banking		
17. FATHER'S NAME (First, Middle, Last): George Lamar Kelly		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Ebberts		
19a. INFORMANT'S NAME (Type/Print): Virginia K. Mortimer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 34 Woodridge West Hartford Ct. 06107		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery	20c. LOCATION — City or Town, State: Balto. Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Davis III		22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins Funeral Home 4905 York Rd. Balto. Md. 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. DILATED CARDIOMYOPATHY	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Francis Khoo ~~FRA~~ STAFF PHYSICIAN	D 30263	▶ 8-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANCIS KHOO ST. JOSEPH HOSPITAL

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	John Davidson-Registrar

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23684
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Joseph	Kostelich	8-28-89	11:50AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
196-26-9495	1 [X] M 2 [ ] F	56 YRS.			4-8-33	PA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
University Hospital	Baltimore City	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD.		BALTimore	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
428 S. PATTERSON PARK AVE	21231	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	PAINTER	PAINTING

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
ATHONY KOSTELICH	ANNA VUCIC

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOSEPH SALANDRA	304 W. PIKE ST. CANONSBURG PA. 15317

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	FOREST LAWN GARDENS	MCMURRAY PA 15317

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
[signature]	DELLANESE & SONS FUNERAL HOME 322 S. HIGH ST BALTO. MD 21202

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO INSPECTION	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Mario F. Golle, Jr., M.D.	111 Penn Street, Baltimore, Maryland 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 23685

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ESTHER M. KLINE			2. DATE OF DEATH (Month, Day, Year): AUGUST 29, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-30-6494	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-15-1907	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): 2603 MANOR AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH: EDGEMERE	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: EDGEMERE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2603 MANOR AVENUE		10f. ZIP CODE: 21219	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 TH GRADE; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): ALONZA S. McCALLIPS		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY A. NIPPLE	
19a. INFORMANT'S NAME (Type/Print): PAUL W. KLINE, SR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2602 MANOR AVENUE BALTIMORE, MARYLAND 21219	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): McCLURE UNION CEM 9-1-1989	20c. LOCATION — City or Town, State: McCLURE, PENNSYLVANIA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gregory E Reed		22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of breast and colon with diffuse metastasis	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: D16619	29d. DATE SIGNED (Month, Day, Year): 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. VERGARA-SOARES 100 N. BROADWAY BALT. MD 21231

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 · FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23686
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen I Landon			2. DATE OF DEATH: MONTH 08 DAY 29 YEAR 89	3. TIME OF DEATH: 3:05 P M
4. SOCIAL SECURITY NUMBER: 219-36-6954D	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 97 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/15/91	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Alice Byrd Tawes Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Crisfield, MD		9c. COUNTY OF DEATH: Somerset

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: Crisfield, MD	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Rt. 2 - Landon's Point		10f. ZIP CODE: 21817	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: - - - -	
17. FATHER'S NAME (First, Middle, Last): Fleming Daugherty		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Ford	
19a. INFORMANT'S NAME (Type/Print): Carolyn Gunter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 525 Silver Lane - Crisfield, MD 21817		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crisfield Cemetery	20c. LOCATION — City or Town, State: Crisfield, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert W. Bradshaw Jr.	22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):	1 WK.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Organic Brain Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Fleetwood MD	29c. LICENSE NUMBER: D10214	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): 320 W. Main St. Crisfield, Md. 21817

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

3

DHMH-16 Rev 1/89

Item#7 Film#g655 09/01/89 da
per F.H. D.J.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23687

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Paul Joseph Maisel					2. DATE OF DEATH (Month, Day, Year): 8-30-89	3. TIME OF DEATH: 3:45PM M
4. SOCIAL SECURITY NUMBER: 214-66-5053	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 34 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): OCTOBER ~~10~~ 17, 1954	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury		9c. COUNTY OF DEATH: Wicomico County	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5446 ADDINGTON ROAD		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BENEFIT AUTHORIZER	16b. KIND OF BUSINESS/INDUSTRY: SOCIAL SECURITY

17. FATHER'S NAME (First, Middle, Last): HERMAN MAISEL	18. MOTHER'S NAME (First, Middle, Maiden Surname): C. ARLENE NORTH
19a. INFORMANT'S NAME (Type/Print): SHEILA MAISEL	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5446 ADDINGTON ROAD, BALTIMORE, MD. 21229

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY	20c. LOCATION — City or Town, State: WOODLAWN, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy M. Witzke	22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary thromboembolism — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Deep leg vein thrombosis — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr. M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D.	111 Penn Street, Baltimore, MD 21201	VC
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Kirkham Sanders	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23688
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mathew 'McCants			2. DATE OF DEATH (Month, Day, Year): August 14, 1989	3. TIME OF DEATH: 1:39 PM
4. SOCIAL SECURITY NUMBER: 212-14-5744	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 27, 1918	8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): Prince George's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly,		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: D.C.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Washington	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3136 Banacker Drive, N.E.		10f. ZIP CODE: 20018	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Miner	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Lucius McCants		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Hudson	
19a. INFORMANT'S NAME (Type/Print): Margaret R. McCants		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3136 Banacker Dr. N.E. Wash. D.C. 20018	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Mem. Cemetery	20c. LOCATION — City or Town, State: Suitland, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ T. Bernard Hunt		22. NAME AND ADDRESS OF FACILITY: Hunt Funeral Home 2801 7th St. N.E. Wash. D.C. 20017	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	Hypertensive cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD	29c. LICENSE NUMBER: D21230	29d. DATE SIGNED (Month, Day, Year): August 14, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Reynolds

DHMH-16 Rev 1/89

Item 8 & 18 corrected Per F.H.film G-655 09/11/89 reb

89 23689

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LAURA V. McCLAIN				2. DATE OF DEATH (Month, Day, Year): 8-30-1989	3. TIME OF DEATH: 1-30 A M
4. SOCIAL SECURITY NUMBER: 212-22-1990	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-24-1900	8. BIRTHPLACE (State or Foreign Country): ~~PENNSULVANIE~~ Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 11300 Loreley Beach Road		9b. CITY, TOWN OR LOCATION OF DEATH: White Marsh		9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: WHITE MARSH	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11300 LORELEY BEACH ROAD		10f. ZIP CODE: 21162	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES: XX	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 TH GRADE; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): NICHOLAS B. KUNSMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ~~MARIE~~ Mary ALICE CURVIN	
19a. INFORMANT'S NAME (Type/Print): MRS. MAE PLEMPEL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11300 LORELEY BEACH ROAD WHITE MARSH, MD 21162	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEM. 9-1-89	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Dundalk, Md. 21222 Duda-Ruck Funeral Home of Dundalk, Inc., 7922 Wise Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. acute Rt C.V.A.	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Parkinsons disease.	> 5 yrs
	c. DUE TO (OR AS A CONSEQUENCE OF): Severe osteoporosis & skyphosis.	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] B. PAREKH MD.	D18424	▶ 8-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. PAREKH ~~Barat Parekh~~, M.D., 1908 Harford Rd., Fallston, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23690
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY IRENE METZEL				2. DATE OF DEATH: MONTH Aug. DAY 29, YEAR 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-01-8504	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 24, 1900	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 3 Hillary Way			9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Cockeysville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3 Hillary Way		10f. ZIP CODE: 21030	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Cornelius Dyke		18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Dunn	
19a. INFORMANT'S NAME (Type/Print): Irene E. Abell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem.Gdns.9/1/89	20c. LOCATION — City or Town, State: Timonium, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks, Jr	22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart failure	1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D07696	29d. DATE SIGNED (Month, Day, Year) ▶ 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. David Nagel 1205 York Road, Lutherville, Md. 21093		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE	

DHMH-18 Rev 1/89

89 23691

1 · FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alverta Meekins			2. DATE OF DEATH (Month, Day, Year): August 30, 1989	3. TIME OF DEATH: 5:55 P.M.
4. SOCIAL SECURITY NUMBER: 215-10-0879	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 20, 1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Garrison Valley Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Garrison, Maryland		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1122 Washington Blvd.		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 yr's; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hat Maker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Thomas R. Meekins		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida May McKee	
19a. INFORMANT'S NAME (Type/Print): John F. Roper	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3726 Evergreen Ave. Baltimore, Md. 21214		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cem. 9/1/89	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock, Jr.	22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Pulmonary Arrest.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Severe ASCVD, Congestive Heart failure.

DUE TO (OR AS A CONSEQUENCE OF):

c. ~~NO~~

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): — 28b. TIME OF INJURY: — M 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED: —
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D32700	29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mohamid Aslam MD Maryland General Hospital Baltimore, Maryland

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 23692

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret E. Marshall			2. DATE OF DEATH (Month / Day / Year): 8 / 31 / 89	3. TIME OF DEATH: 11:55 AM
4. SOCIAL SECURITY NUMBER: 217-20-6988	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month / Day / Year): 2-26-14	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2202 Ashton Street		10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unavailable; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Roy T. Perrel	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Esworthy	
19a. INFORMANT'S NAME (Type/Print): Mary L. Gill	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 447 S. Furrow St. Baltimore, MD 21223	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon	22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA OF LUNG	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Diseases

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Good Samaritan Hospital

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mei-Yee MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8. 31. 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHOW, Mei-Yee MD Good Samaritan Hospital		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23693

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roy Glendon MEYER			2. DATE OF DEATH (Month / Day / Year): 8 / 29 / 89	3. TIME OF DEATH: 9:34 A M
4. SOCIAL SECURITY NUMBER: 196-09-3265	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-21-1908	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: ROSSVILLE		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: DUNDALK	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 43 WATERVIEW ROAD		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 TH GRADE; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CRANE OPERATER	16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL CORP.	
17. FATHER'S NAME (First, Middle, Last): DANIEL H. MEYER		18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA JANE MILLER	
19a. INFORMANT'S NAME (Type/Print): IDA MAE MEYER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 43 WATERVIEW ROAD BALTIMORE, MARYLAND 21222	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BEL AIR MEMORIAL GARDENS 9-1-89	20c. LOCATION — City or Town, State: BEL AIR, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary P. Duda		22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary arrest	
DUE TO (OR AS A CONSEQUENCE OF): b.	pulmonary lesion	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	COPD	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ronald Attanasio	29c. LICENSE NUMBER: D-28097	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1012 OLD N. Point Rd. Balt. Md - 21224.

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 23694

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIE F. NIEBERDING / Marie F. Nieberding		2. DATE OF DEATH: MONTH 8 DAY 30 YEAR 89	3. TIME OF DEATH: 10 P. M
4. SOCIAL SECURITY NUMBER: 218-46-4539	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (If less than last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12/26/05
8. BIRTHPLACE (State or Foreign Country): Balto. Md			
9a. FACILITY NAME (If not institution, give street and number): Stella Maris HOSPICE	9b. CITY, TOWN OR LOCATION OF DEATH: Towson MD 21204	9c. COUNTY OF DEATH: Balto. County	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: ------	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3103 CHESTERFIELD AVE.	10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): HENRY GUTBERLET	18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH ----		
19a. INFORMANT'S NAME (Type/Print): RALPH M. MURDY ESQ,	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5718 HARFORD RD., Baltimore, Md. 21214		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER	20c. LOCATION — City or Town, State: BALTIMORE MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Carla A. Alexander MD	29c. LICENSE NUMBER: D27087	29d. DATE SIGNED (Month, Day, Year): 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla Alexander M.D. 2300 Dulaney Valley Road Towson, MD 21204

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

15

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23695
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Julia Rada Julia M. Rada			2. DATE OF DEATH (Month, Day, Year): 8 30 89	3. TIME OF DEATH: 1146 M
4. SOCIAL SECURITY NUMBER: 216-05-1832	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10 17 17	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): MIEMSS / Shock Trauma		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Balto.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 7203 Willowdale Ave.		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): File Clerk	16b. KIND OF BUSINESS/INDUSTRY: Social Security	
17. FATHER'S NAME (First, Middle, Last): Michael Bretzl		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Steigerwald	
19a. INFORMANT'S NAME (Type/Print): James J. Rada		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7203 Willowdale Ave. Balto., Md. 21206	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Cem.	20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. uncontrolled hypovolemia, hypotension
DUE TO (OR AS A CONSEQUENCE OF):
c. aortic aneurysm abdominal, ruptured
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
hypertension
coronary artery disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO declined

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 8/30/89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chris Pieruccini MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHRIS PIERUCKI MD - MIEMSS

31. DATE FILED (Month, Day, Year): SEP 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rowles

DHMH-16 Rev 1/89

89 23696

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EUGENE M. ROBERTS				2. DATE OF DEATH (Month, Day, Year): 8 / 30 / 89	3. TIME OF DEATH: 6:30 A M
4. SOCIAL SECURITY NUMBER: 215-09-8263	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8/24/12	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 817 St. Paul Street Apt. 810		10f. ZIP CODE: 21202		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.): Maintanence		16b. KIND OF BUSINESS/INDUSTRY: Mercy Hospital	
17. FATHER'S NAME (First, Middle, Last): Unavailable		18. MOTHER'S NAME (First, Middle, Maiden Surname): Unavailable			
19a. INFORMANT'S NAME (Type/Print): Mildred Roberts		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 St. Paul Street Apt. 810 Baltimore, Md. 21202			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery		20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L Goff		22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Heart Block	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ischemic Heart disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
R Chan, M.D.		▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. R. CHAN, MD 307 St. Paul Place Baltimore MD 21202

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Gwen Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23697 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hazel Virginia Ridgley			2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89	3. TIME OF DEATH: 1 A M
4. SOCIAL SECURITY NUMBER: 212 74 6297	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-6-07	8. BIRTHPLACE (State or Foreign Country): MD
8a. FACILITY NAME (If not institution, give street and number): 1041 Marlboro Rd.		9b. CITY, TOWN OR LOCATION OF DEATH: Lothian		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Lothian		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1041 Marlboro Rd.		10f. ZIP CODE: 20711		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: -		
17. FATHER'S NAME (First, Middle, Last): William Ridgley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Hungerford		
19a. INFORMANT'S NAME (Type/Print): James A. Ridgley	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1039 Marlboro Rd., Lothian, MD 20711			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Calvary Cemetery	20c. LOCATION — City or Town, State: Lothian (AA) MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. Michael Rausch RFH	22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac arrest	Instant
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic cardiovascular dis.	10 yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	DO 5259	▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

DNMN-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 23698

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Triwayne Springfield		2. DATE OF DEATH (Month, Day, Year): 8-29-89	3. TIME OF DEATH: 11:10PM M
4. SOCIAL SECURITY NUMBER: 215-86-4763	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 15 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 2/04/74
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5112 GROTON ROAD	10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STUDENT	16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): LARRY JOHNSON	18. MOTHER'S NAME (First, Middle, Maiden Surname): DRUSILLA SPRINGFIELD		
19a. INFORMANT'S NAME (Type/Print): DRUSILLA JOHNSON	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5112 GROTON ROAD/BALTIMORE, MD 21206		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY	20c. LOCATION — City or Town, State: CATONSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas Davis	22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Drowning
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient XXX 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural XXX [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-29-89	28b. TIME OF INJURY: 10:00P	28c. INJURY AT WORK? 1 [ ] YES 2 XX [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Subject drowned	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Swim Club-Pool	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Garden Village Swim Club, 5502 Denvieway, Baltimore City, MD	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin, M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, Maryland 21201 vc		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23699

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY MARIE SISTEK / DOROTHY SISTEK				2. DATE OF DEATH (Month, Day, Year) 08-31-89	3. TIME OF DEATH 2355 M
4. SOCIAL SECURITY NUMBER 213-28-1929	5. SEX 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday) 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV. 30 1930	8. BIRTHPLACE (State or Foreign Country) MD.

9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	9c. COUNTY OF DEATH -----

RESIDENCE OF DECEDENT

10a. STATE MD.	10b. COUNTY HARFORD	10c. CITY, TOWN OR LOCATION BEL AIR	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 2837 FORGE HILL RD.		10f. ZIP CODE 21014	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) GILBERT WETHERINGTON		18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE GETZ	
19a. INFORMANT'S NAME (Type/Print) CHARLES W. SISTEK (HUSBAND)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2837 FORGE HILL RD., BEL AIR MD. 21014	
20a. METHOD OF DISPOSITION ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. IGNATIUS CHURCH CEM.	20c. LOCATION — City or Town, State HICKORY, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ John F. Schimunek		22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOME INC. 9705 Belair Rd. Balto. Md. 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LYMPHOMA LYMPHOCYTIC	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PANCYTOPENIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Joseph Quist INTERN	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOSEPH QUIST MD. GOOD SAMARITAN HOSP 5601 LOCKRAVEN BLD. BALTIMD

31. DATE FILED (Month, Day, Year) SEP 1 1989	32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23700

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY SCHATZ						2. DATE OF DEATH: MONTH 8 DAY 28 YEAR 89	3. TIME OF DEATH: 3:24 PM	
4. SOCIAL SECURITY NUMBER: 212-50-3570	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): OCT. 5 1913	8. BIRTHPLACE (State or Foreign Country): TENN.	
9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE			9c. COUNTY OF DEATH: ------		
RESIDENCE OF DECEDENT								
10a. STATE: MD.	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: SEVERN				10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO		
10e. STREET AND NUMBER: 1230 SOMERSET RD.			10f. ZIP CODE: 21144			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RECEPTIONIST				16b. KIND OF BUSINESS/INDUSTRY: BEAUTY SHOP		
17. FATHER'S NAME (First, Middle, Last): JAMES ELMER ANDERSON						18. MOTHER'S NAME (First, Middle, Maiden Surname): LADYE HAZEL McCARVER		
19a. INFORMANT'S NAME (Type/Print): LADYE PARSONS (DGHTR)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 226 CHEDDINGTON RD., LINTHICUM MD. 21090		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK				20c. LOCATION — City or Town, State: BALTIMORE, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Schimunek						22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory srrest, shock, or haart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Pulmonary Embolism	10 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. Deep Venous Thrombosis	20 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Sepsis	10 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Congestive Heart Failure	26 Days

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] M.D. Med. Intern		▶ 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL H. ROSLER Harbor Hospital Center

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
8-SEP 81 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23701

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Venus Ann Shifflett			2. DATE OF DEATH (Month, Day, Year): 8-28-89	3. TIME OF DEATH: 6:50PM M
4. SOCIAL SECURITY NUMBER: 220-82-3556	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 26 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 20, 1963	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: ---------

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Balto.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3311 Bero Rd.		10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 years; College (1-4 or 5+): ------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator	16b. KIND OF BUSINESS/INDUSTRY: Factory	
17. FATHER'S NAME (First, Middle, Last): Nowell E. Montz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie C. Darr	
19a. INFORMANT'S NAME (Type/Print): Mrs.Marie Montz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3311 Bero Rd.Balto.Md.21227	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Mem.Park	20c. LOCATION — City or Town, State: Md. Elkridge,Howard Co.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stuart D. Schwartzman		22. NAME AND ADDRESS OF FACILITY: Balto.Md.21230 McCully Funeral Home,130 E.Fort Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wounds to left hand and head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-27-89	28b. TIME OF INJURY: 8:15 PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3311 Bero Road, Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,M.D.	111 Penn Street, Baltimore,MD 21201	VC
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: [illegible]	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23702
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANN MARIE FLORIN-SIMPSON				2. DATE OF DEATH (Month, Day, Year): 08 29 1989	3. TIME OF DEATH: 23.20 M
4. SOCIAL SECURITY NUMBER: 212-10-6782	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8/21/16	8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Halethorpe	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1304 Elm Road		10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Proprietor	16b. KIND OF BUSINESS/INDUSTRY: Bakery	
17. FATHER'S NAME (First, Middle, Last): Henry Volkman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Doerfert	
19a. INFORMANT'S NAME (Type/Print): Joseph B. Simpson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1304 Elm Road Halethorpe, Md. 21227		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christopher N. Miles	22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrst	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Diffuse liver mets. with unknown primary	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hepatic encephalopathy. secondary to diffuse liver mets

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ileana Gheorghiu, M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ILEANA GHEORGHIU, M.D. Union Memorial Hospital		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

UNKNOWN 89-156

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23703
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Walter F. Szymanik			2. DATE OF DEATH (Month, Day, Year): 8-30-89	3. TIME OF DEATH: 9:30PM M
4. SOCIAL SECURITY NUMBER: 218 28 8863	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 4 1934	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Eastern Avenue at Hartman		9b. CITY, TOWN OR LOCATION OF DEATH: Essex Baltimore County		9c. COUNTY OF DEATH: Baltimore County
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 333 Magnolia Terrace		10f. ZIP CODE: 21221		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fork Lift Operator	16b. KIND OF BUSINESS/INDUSTRY: American Can		
17. FATHER'S NAME (First, Middle, Last): Lucas Szmanik		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Wiecorek		
19a. INFORMANT'S NAME (Type/Print): Rith D. Szymanik, Wife	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 333 Magnolia Terrace Balto., Md. 21221			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Garrison Forest Balto Co.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A CONSEQUENCE OF):	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify): Scene		
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-30-89	28b. TIME OF INJURY: 8:29P M	28c. INJURY AT WORK? 1 [ ] YES [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Pedestrian struck by car	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Eastern Avenue/Hartman, Balto. City, Maryland	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr. M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23704
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John G. Thompson			2. DATE OF DEATH (Month, Day, Year): 8-30-89	3. TIME OF DEATH: 5:28PM M
4. SOCIAL SECURITY NUMBER: 226 18 2845	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 20 1917	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: ---

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1632 "B" Dartford Rd.	10f. ZIP CODE: 21221		10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Cemetery	
17. FATHER'S NAME (First, Middle, Last): William J. Thompson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Gray	
19a. INFORMANT'S NAME (Type/Print): Violet Mae Thompson, Wife		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1632 "B" Dartford Rd. Balto., Md. 21221	
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Antioch Bap Ch Cemetery	20c. LOCATION — City or Town, State: Scottville, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Irene Bruzdzinski		22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Diabetes Mellitus	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fracture left femur

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XXX 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [ ] Natural XXX 2 Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-27-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES XXX 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject fell out of bed
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Nursing Home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 501 W. Franklin St.-Seton Hill Manor, Baltimore City, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. md	29c. LICENSE NUMBER: OCME	29d. DATE SIONED (Month, Day, Year): 8-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle,Jr.,MD 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 1 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23705

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCIS E. WEISS
2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89
3. TIME OF DEATH: 1:30 am M
4. SOCIAL SECURITY NUMBER: 209-14-8191
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-2-26
8. BIRTHPLACE (State or Foreign Country): Pa.
9a. FACILITY NAME (If not institution, give street and number): Loch Raven Veterans Adm Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Port Deposit
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: Oak Lane Trailor Ct.
10f. ZIP CODE: 21904
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled Veteran
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Peter Agnes Weiss
18. MOTHER'S NAME (First, Middle, Maiden Surname): ULshafer Weiss
19a. INFORMANT'S NAME (Type/Print): James Evans Funeral Home
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 347 S. Second St. St. Clair, Pa. 17970
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): My Lady of Calvary
20c. LOCATION — City or Town, State: Pottsville, Pa. 17901
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edison M. Perkins
22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins Funeral Home 4905 York Rd. Balto. Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. SQUAMOUS CELL CA FACE

DUE TO (OR AS A CONSEQUENCE OF):

c. _____

DUE TO (OR AS A CONSEQUENCE OF):

d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Loch Raven VA Hosp Baltimore Md
31. DATE FILED (Month, Day, Year): SEP 7 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Irene young - 366 9

89 23706

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IRENE E. YOUNG			2. DATE OF DEATH (Month, Day, Year): AUG 31, 1989	3. TIME OF DEATH: 9:29 A. M
4. SOCIAL SECURITY NUMBER: 216-05-9426	5. SEX: 1 ☐ M 2 ☒ F XX	5. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 21, 1908	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: HARFORD	10c. CITY, TOWN OR LOCATION: JOPPA		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ XX NO
10e. STREET AND NUMBER: 104 CANBY CT.		10f. ZIP CODE: 21085		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): WILLIAM BECK		18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA SAUL		
19a. INFORMANT'S NAME (Type/Print): MRS. WILMA HANSON WILEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 CANBY CT. JOPPA MD. 21085		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY		20c. LOCATION — City or Town, State: BALTIMORE MD. 21229
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edison M. Perkins Jr.		22. NAME AND ADDRESS OF FACILITY: H.W. JENKINS AND SONS CO. 4905 YORK RD. BALTO. MD. 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute MI	1/2 hr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ischemic Cardiomyopathy	7 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gregory S. Ader MD	D 25620	▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3300 N. Calvert St BALTO MD 21218

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julie Barnes

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23707

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sophie Baker
2. DATE OF DEATH — MONTH: 8 DAY: 30 YEAR: 89
3. TIME OF DEATH: 12:45 M
4. SOCIAL SECURITY NUMBER: 216-12-5702
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/17/04
8. BIRTHPLACE (State or Foreign Country): Balto, Md.
9a. FACILITY NAME (If not institution, give street and number): Eastpoint Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: ~~620 S. Makon St.~~ error Balto.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 620 S. Makon St.
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JOHN DORN
18. MOTHER'S NAME (First, Middle, Maiden Surname): SOPHIA SUMINSKA
19a. INFORMANT'S NAME (Type/Print): MARLENE HUTTON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8029 EASTDALE RD BALTO. MD. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY
20c. LOCATION — City or Town, State: BALTO. CO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew L. Burdell
22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler Inc. 1901 Eastern Ave. 21231

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	Immediate
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D0 42277
29d. DATE SIGNED (Month, Day, Year): 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH J. CAMERIN M.D. 1- SMETON PL. TOWSON, MD 21204
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23708
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Agnes M. Bach			2. DATE OF DEATH (Month, Day, Year): September 3, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213.03.8589	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 24, 1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 4 Willowdale Avenue (Ferndale)		9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4 Willowdale Avenue (Ferndale)		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 5+): NA	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Daniel Edward Garvey, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa Bauernfiend	
19a. INFORMANT'S NAME (Type/Print): Mary Kaye Graves		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Rosedale Avenue (Ferndale), Glen Burnie, Md.21061	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Harge Hopkins		22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, 1 Second Ave. S.W., Glen Burnie, Md. 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. (ST) Stroke Cerebral Vascular Accident	Seconds
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Basilar Artery Dilation	Several Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Congestive Heart Failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sue W. Thompson MD	29c. LICENSE NUMBER: D22842	29d. DATE SIGNED (Month, Day, Year) ▶ 9/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sue W. Thompson, MD, 3918 Potee St., Baltimore, Md 21225		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: [illegible] Davidson-Vandegrift	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23709 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Samuel Smiley Badders				2. DATE OF DEATH (Month, Day, Year): 8 30 89	3. TIME OF DEATH: 9 34 A M
4. SOCIAL SECURITY NUMBER: 218-18-6652	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 23, 1904	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hosp		9b. CITY, TOWN OR LOCATION OF DEATH: Fallston MD		9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Pylesville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4961 Rocks Road		10f. ZIP CODE: 21132	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Farming	
17. FATHER'S NAME (First, Middle, Last): Samuel Smiley Badders		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth C. Gibbs	
19a. INFORMANT'S NAME (Type/Print): Naomi C. Badders		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4961 Rocks Road, Pylesville, MD 21132	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ayres Chapel Cemetery	20c. LOCATION — City or Town, State: White Hall, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. J. Hartenstein		22. NAME AND ADDRESS OF FACILITY: Hartenstein-Orsburn Funeral Home, 19 S. Main St., Stewartstown, PA 17363	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Brain Death	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Massive Cerebral Edema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cerebral Contusion	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Fall at home	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28e. DATE OF INJURY (Month, Day, Year): 8/28/89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Patient slipped on stairs
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4961 Rocks Road Pylesville

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: D23446	29d. DATE SIGNED (Month, Day, Year): 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. [illegible] 106 1716 Hartford Rd. Fallston Md 21047

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall

Richard J. Coyle MD Dep Med Examiner D 11946 2013 Trappe Church Road Darlington, MD 21034 8/30/89

VSMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23710

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GARNETT BOWEN				2. DATE OF DEATH (Month, Day, Year): 8 31 89	3. TIME OF DEATH: 6:30 a M
4. SOCIAL SECURITY NUMBER: 224 - 24 - 8904	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 27, 1918	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Odenton	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 488 Patuxent Road # 13		10f. ZIP CODE: 21113	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic	16b. KIND OF BUSINESS/INDUSTRY: Maryland Forestry Service	
17. FATHER'S NAME (First, Middle, Last): William Frazier Bowen		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha May Redman	
19a. INFORMANT'S NAME (Type/Print): Mary Bowen		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 488 Patuxent Road #13 Odenton, Maryland 21113	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Dorsey, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donaldson L.F.		22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE CARDIOMYOPATHY	2 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	6+ YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION
VENTRICULAR ARRHYTHMIA

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E.S. Machado MD	29c. LICENSE NUMBER: D24035	29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E.S. MACHADO MD 321 PRINCE GEORGE STREET		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23711

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles L. Chase, Jr.			2. DATE OF DEATH (Month, Day, Year): 8 30 89	3. TIME OF DEATH: 12:25 PM
4. SOCIAL SECURITY NUMBER: 213-62-9557	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-10-53	8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital 301 St Paul Place
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD		BALTIMORE	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
5402 SARRIL ROAD APT D	21206	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	UNEMPLOYED	NA

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
CHARLES L. CHASE, SR.	MARGARET DORSEY

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CHARLES CHASE, SR.	5402 SARRIL ROAD APT D/BALTIMORE, MD 21206

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	KING MEMORIAL PARK	RANDALLSTOWN, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Williams
22. NAME AND ADDRESS OF FACILITY: WM. C. M ARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Hypertension	Months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Probably Pulmonary Embolism	
	DUE TO (OR AS A CONSEQUENCE OF): c. I.V. Drug abuse	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO pending	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
R Chan, MD		▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. CHAN 301 St. Paul Place Baltimore Md 21202

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

89-23712

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23712

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Salvatore A. Corona
2. DATE OF DEATH: MONTH 8 DAY 30 YEAR 89
3. TIME OF DEATH: 5:35 A M
4. SOCIAL SECURITY NUMBER: 358-05-1284
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08-10-1921
8. BIRTHPLACE (State or Foreign Country): ILLINOIS
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia Howard Co. MD.
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Balto
10c. CITY, TOWN OR LOCATION: Baltimore County
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 935 Prestwood Rd.
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 6+): 2 YRS.
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Policeman
16b. KIND OF BUSINESS/INDUSTRY: Balto. Police Force
17. FATHER'S NAME (First, Middle, Last): Joseph Corona
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fellina Camisa
19a. INFORMANT'S NAME (Type/Print): Ann Corona
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 935 Prestwood Rd. Balto. Md. 21228
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Natl. Cemetery
20c. LOCATION — City or Town, State: Balto. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen Vickers
22. NAME AND ADDRESS OF FACILITY: 5311 Edmondson Ave Edward J. Weber F.H.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	2-3 hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Ischemic Cardiomyopathy	Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Coronary Artery Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jerome Hamilton, MD
29c. LICENSE NUMBER: 015043
29d. DATE SIGNED (Month, Day, Year): ▶ 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Lia Feinberg-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23713
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SOON IM CHO		2. DATE OF DEATH (Month, Day, Year): 9 / 1 / 89	3. TIME OF DEATH: ~~9:55~~ 9:40 M
4. SOCIAL SECURITY NUMBER: 215-78-1872	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/18/17
8. BIRTHPLACE (State or Foreign Country): Korea			

8a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 909 Lucabaugh Mill Road		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY? Perm.Resident

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Korean

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
		16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Unknown Song	18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown Cho
19a. INFORMANT'S NAME (Type/Print): Pius Y. Cho	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 909 Lucabaugh Mill Road Westminster, Md. 21157

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakeview Memorial Gardens	20c. LOCATION — City or Town, State: Sykesville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. meningitis	weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D18146	29d. DATE SIGNED (Month, Day, Year) ▶ 9 / 1 / 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Duncan McCormick MD FSKMC 4940 Eastern Ave Balt. MD 21224

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23714

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SAMUEL MONROE CROGHAN, SR.
2. DATE OF DEATH: MONTH 9 DAY 01 YEAR 1989
3. TIME OF DEATH: 17.30 M
4. SOCIAL SECURITY NUMBER: 275-18-7595
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 4/23/21
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 902 Pine Heights Ave.
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [X] NO IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter
16b. KIND OF BUSINESS/INDUSTRY: Trailer
17. FATHER'S NAME (First, Middle, Last): Alva Croghan
16. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Wood
19a. INFORMANT'S NAME (Type/Print): Patricia A. Croghan
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 902 Pine Heights Ave. Baltimore, Md. 21229
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cemetery
20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HTN; PVD

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY M:
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Selim Inel, M.D. (Med. Resident)
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 09/01/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAH Dr. Selim INEL Dept. of Medicine
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Githa Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23715 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROY D COOK			2. DATE OF DEATH (Month, Day, Year): Aug. 28 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 25, 1915	8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 617 Rosedale Street		10f. ZIP CODE: 21216	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Laborer	16b. KIND OF BUSINESS/INDUSTRY: Charles Scribner Construction

17. FATHER'S NAME (First, Middle, Last): Thomas Cook	18. MOTHER'S NAME (First, Middle, Maiden Surname): Pattie Mae Snowall
19a. INFORMANT'S NAME (Type/Print): Mary Cook	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 617 Rosedale Street Baltimore, Maryland 21216

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	20c. LOCATION — City or Town, State: Baltimore County, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon R. Bailey	22. NAME AND ADDRESS OF FACILITY: Nutter Funed Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Cardiac Arrythmias - Ventricular

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure
Hypertension.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Komal K. Dang M.D.	29c. LICENSE NUMBER: D18362	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KOMAL K. DANG M.D. 700 Washington Blvd. Balto MD 21030

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Lidia Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23716 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ottolie Y. W. Cochran			2. DATE OF DEATH (Month / Day / Year): 9 / 4 / 89	3. TIME OF DEATH: 6:50 P.M.
4. SOCIAL SECURITY NUMBER: 215-46-7024	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/2/03	8. BIRTHPLACE (State or Foreign Country): Chicago, Ill.
9a. FACILITY NAME (If not institution, give street and number): 3107 Golf Course Road-West		9b. CITY, TOWN OR LOCATION OF DEATH: Owings Mills		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Owings Mills		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3107 Golf Course Rd.-West		10f. ZIP CODE: 21117		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Home Owner
17. FATHER'S NAME (First, Middle, Last): Byron F. Hobart, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Osbourne		
19a. INFORMANT'S NAME (Type/Print): Walter W. Brewster		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13401 Longnecker Rd., Glyndon, Md.		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Thomas Church-Garrison		20c. LOCATION — City or Town, State: Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Davis III		22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins Funeral Home 4905 York Rd. Balto. Md. 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac failure	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary heart Disease	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gangrene of leg

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William F Fritz MD

29c. LICENSE NUMBER: F 6302

29d. DATE SIGNED (Month, Day, Year): ▶ 9/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William F. Fritz 500 W. University Pkwy. Baltimore, Md.

31. DATE FILED (Month, Day, Year): SEP 5 1989

32. REGISTRAR'S SIGNATURE: Jessie Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23717

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry Albert Campbell, Jr.				2. DATE OF DEATH (Month, Day, Year): September 4, 1989	3. TIME OF DEATH: 1 P M
4. SOCIAL SECURITY NUMBER: 216.01.4266A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 30, 1905	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Summitt Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville		9c. COUNTY OF DEATH: Baltimore Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 714 Wellham Avenue (Ferndale)		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): NA	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Driver (Ret)	16b. KIND OF BUSINESS/INDUSTRY: National Distillery	
17. FATHER'S NAME (First, Middle, Last): Harry Albert Campbell, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Jones	
19a. INFORMANT'S NAME (Type/Print): Gertrude C. Campbell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 714 Wellham Avenue (Ferndale), Glen Burnie, Md. 21061		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins	22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, 1 Second Ave. S.W., Glen Burnie, Maryland 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Myasthenia Gravis

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James E Rowe MD	29c. LICENSE NUMBER: D13170	29d. DATE SIGNED (Month, Day, Year): ▶ Sept. 5, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James E. Rowe, M. D. 413 Commonwealth Avenue Baltimore, Maryland 21228		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: John Davidson-Randall	

DHMH-16 Rev 1/89

Item10a,b,c,e,Film689,7/14/92,lt

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23718

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES AKA: JAMES F. SLOCUM DIMITRI				2. DATE OF DEATH: MONTH 9 DAY 3 YEAR 1989	3. TIME OF DEATH: 9:23 A M
4. SOCIAL SECURITY NUMBER: 205-14-2847	5. SEX: 1 ☐ M 2 ☐ F X	6. AGE (In yrs. last birthday): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Apr. 24, 1926	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): University Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Penn. Maryland	10b. COUNTY: Philadelphia	10c. CITY, TOWN OR LOCATION: Philadelphia Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: ~~501 S. Eutaw St.~~ 119 N. Bodine Street		10f. ZIP CODE: ~~21201~~ 19123	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner	16b. KIND OF BUSINESS/INDUSTRY: Livery Service	
17. FATHER'S NAME (First, Middle, Last): Joseph E. Slocum		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne Marie McAleer	
19a. INFORMANT'S NAME (Type/Print): Joseph Slocum		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1023 Rivera, Warminster, PA 18974	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Sepulcher	20c. LOCATION — City or Town, State: Cheltenham, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Gene Altenburg		22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries with complications	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

	24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-19-89	28b. TIME OF INJURY: 7:20P M	28c. INJURY AT WORK? 1 X YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED: Operator of horse & buggy carriage/auto collision
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 300 blk. S. Howard St. at Camden St., Balto. City, MD

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chas P. Kokes MD	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 9-4-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23719
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN R. DEMBOWSKI			2. DATE OF DEATH (Month, Day, Year): XXXXXX 9/2/89	3. TIME OF DEATH: 4:30 AM
4. SOCIAL SECURITY NUMBER: 216-03-7370	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 9/22/XX	8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 28 N. DECKER AVE.	10f. ZIP CODE: 21224		10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LONGSHOREMAN	16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): WALTER DEMBOWSKI	18. MOTHER'S NAME (First, Middle, Maiden Surname): MICHALENA BOGUCKI

19a. INFORMANT'S NAME (Type/Print): FRANCES DEMBOWSKI	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 N. DECKER AVE BALTO. MD. 21224

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Rosary Cemetery	20c. LOCATION — City or Town, State: BALTO. MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David J. Weber	22. NAME AND ADDRESS OF FACILITY: EDWARD J. WEBER 401 S. Chester St.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE GI BLEEDING

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute GI bleeding

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Lymphoma LYMPHOMA

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. ZUGHAYB MD	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): 9/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHURCH HOSPITAL	DR. ZUGHAYB, M.D. CHURCH HOSPITAL

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23720

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~ENGELBRECHT~~ SALOME ~~C~~ C. Engelbrecht

2. DATE OF DEATH Month: 8 Day: 28 Year: 89

3. TIME OF DEATH: 5:05 PM

4. SOCIAL SECURITY NUMBER: 214103567

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10/24/02

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Ctr 3001 So. Hanover St

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD

9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: McMECHEN MEMORIAL APTS.

10f. ZIP CODE: 21217

10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 10 YRS.
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): L.P.N.

16b. KIND OF BUSINESS/INDUSTRY: NURSING

17. FATHER'S NAME (First, Middle, Last): LEWIS CRUM

18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA FOWLER

19a. INFORMANT'S NAME (Type/Print): B. LEONARD ENGELBRECHT

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 S. MONTFORD AVE. BALTO. MD. 21224

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY

20c. LOCATION — City or Town, State: BALTO. CO. MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catherine M. Zeiler

22. NAME AND ADDRESS OF FACILITY: LILLY + ZEILER, INC. F.H. 1901 EASTERN AVE. BALTO. MD. 21231

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia	8/18/89
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	UTI	to 8/28/89
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Multiple CVA	
DUE TO (OR AS A CONSEQUENCE OF):		
d.	ANEMIA	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Parkinson's disease.
ASCVD pulmonary T.B. pulmonary Embolism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dr M. Goldberg

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harbor Hospital Ctr 3001 S. Hanover St. S. Baltimore, MD

31. DATE FILED (Month, Day, Year): SEP 5 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23721

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAROLD THURSTON ELLIS					2. DATE OF DEATH (Month, Day, Year): Aug. 25, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 219-05-0411	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 22, 1910	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 4123 Granada Ave.			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 4123 Granada Ave.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chauffer/Forman	16b. KIND OF BUSINESS/INDUSTRY: Baltimore City Public Works	
17. FATHER'S NAME (First, Middle, Last): Charles Ellis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rachel Howard	
19a. INFORMANT'S NAME (Type/Print): Hilda C. Ellis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4123 Granada Ave. Baltimore, Maryland 21215	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery	20c. LOCATION — City or Town, State: Baltimore County, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R Ferry Jr.		22. NAME AND ADDRESS OF FACILITY: 2501 Gwynns Falls Pkwy. Nutter Funeral Homes, Inc Baltimore, Maryland 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Raymond A. Nze MD, MPH	D34184	▶ 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7801 YORK RD #300, TOWSON MD 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Juba Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23722

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JULIA M. FRANZONI
2. DATE OF DEATH (Month, Day, Year): Sept. 1, 1989
3. TIME OF DEATH: 2:45 AM
4. SOCIAL SECURITY NUMBER: 212-07-9681
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov.1,1915
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University of MD Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: ----------

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore County
10c. CITY, TOWN OR LOCATION: Parkville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1909 Redwood Ave.
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years — College (1-4 or 5+): ----------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Church
17. FATHER'S NAME (First, Middle, Last): George L. Brigerman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Upright
19a. INFORMANT'S NAME (Type/Print): Mary E. Duncan
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2107 Rosante Ct. Fallston, Maryland 21047
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park
20c. LOCATION — City or Town, State: Balto.Co.,Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William E. Johnson
22. NAME AND ADDRESS OF FACILITY: William E. Johnson funeral Home,P.A. 8521 Loch Raven Blvd.Towson,MD21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Leiomyosarcoma	6yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jeffrey C. Brackett MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey C. Brackett MD
31. DATE FILED (Month, Day, Year): 9/SEP/89 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23723

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Otto W. FELSCH Felsch (OTTO)
2. DATE OF DEATH: MONTH 9-3 DAY 89 YEAR (9-3-89)
3. TIME OF DEATH: 3:45 PM
4. SOCIAL SECURITY NUMBER: 212-10-3336
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 87 (87 YRS.) IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-19-01 (12-14-01)
8. BIRTHPLACE (State or Foreign Country): BALTO, MD.
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL, INC.
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, M.D.
9c. COUNTY OF DEATH: BALTO

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Cockeysville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 10331 Malcolm Circle
10f. ZIP CODE: 21030
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondery (0-12): ; College (1-4 or 6+): College-4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mgr. Personel REcords
16b. KIND OF BUSINESS/INDUSTRY: Matyland Casulty Co.
17. FATHER'S NAME (First, Middle, Last): Otto E. Felsch
18. MOTNER'S NAME (First, Middle, Maiden Surname): Josephine
19a. INFORMANT'S NAME (Type/Print): Julia J. Felsch
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10331 MAlcolm Circle Apt. D Cockeysville, Md 21030
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Park
20c. LOCATION — City or Town, State: Cockeysville, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy
22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE, ELECTROLYTE IMBALANCE
DIGOXIN TOXICITY

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Francis Khoo STAFF PHYSICIAN
29c. LICENSE NUMBER: D 30263
29d. DATE SIGNED (Month, Day, Year): ▶ 9-3-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANCIS KHOO ST. JOSEPH HOSPITAL
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23724
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHLOE LEE FREELS		2. DATE OF DEATH (Month, Day, Year): September 1, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 433-42-5920	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-7-00
8. BIRTHPLACE (State or Foreign Country): Tennessee			
9a. FACILITY NAME (If not institution, give street and number): 912 Locustvale Road	9b. CITY, TOWN OR LOCATION OF DEATH: Towson	9c. COUNTY OF DEATH: Baltimore County	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Towson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 912 Locustvale Road	10f. ZIP CODE: 21204	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Broker	16b. KIND OF BUSINESS/INDUSTRY: Real Estate	
17. FATHER'S NAME (First, Middle, Last): Hugh Benjamin Chapman	18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Elvira Thompson		
19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia F. Wilson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10e		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Highland Memorial	20c. LOCATION — City or Town, State: Knoxville , Tennessee	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Coronary Heart Disease	10 years
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J Myrton Gaines Jr. MD.	29c. LICENSE NUMBER: D03656	29d. DATE SIGNED (Month, Day, Year): ▶ September 2, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Myrton L. Gaines, Jr. M.D. , 6565 N. Charles St. , Towson, Maryland 21204		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23725
REG. NO.

10

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Luther Jackson Fewell			2. DATE OF DEATH (Month, Day, Year): 8 31 89	3. TIME OF DEATH: 3:47 P. M
4. SOCIAL SECURITY NUMBER: 230-40-4465	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2/1/36	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Virginia	10b. COUNTY: Fairfax	10c. CITY, TOWN OR LOCATION: Chantilly	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4149 Meadow Land Court		10f. ZIP CODE: 22021	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter	16b. KIND OF BUSINESS/INDUSTRY: Building	
17. FATHER'S NAME (First, Middle, Last): James William Fewell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel M. Haley	
19a. INFORMANT'S NAME (Type/Print): Fontiella L. Fewell (Mrs.)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4149 Meadow Land Court, Chantilly, VA 22021	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Warrenton Cemetery	20c. LOCATION — City or Town, State: Warrenton, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph T. Smith		22. NAME AND ADDRESS OF FACILITY: Moser Funeral Home, Inc. 233 Broadview Ave., Warrenton, VA 22186	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Right Coronary Artery Thrombosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Mae Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 9-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Balto., Md. 21201

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23726

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): REMSEN S FRASER			2. DATE OF DEATH (Month, Day, Year): 8 29 89	3. TIME OF DEATH: 0115 M
4. SOCIAL SECURITY NUMBER: 205-20-3350	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 14, 1898	8. BIRTHPLACE (State or Foreign Country): Iowa
9a. FACILITY NAME (If not institution, give street and number): WASH. ADV. HOSP		9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PK.		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 1607 Chestermill Terrace		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 6	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: University
17. FATHER'S NAME (First, Middle, Last): Walter A. Fraser		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Scott	
19a. INFORMANT'S NAME (Type/Print): Margaret Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 233 Madison Rd. Willow Grove, Pennsylvania 19091	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillside Cemetery	20c. LOCATION — City or Town, State: Roslyn, Pennsylvania
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey L. Campbell		22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, Va.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Congestive Heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Aortic Stenosis
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic renal failure
DUE TO (OR AS A CONSEQUENCE OF):
d. Infection (2) Cough.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kenneth Salhotra MD	29c. LICENSE NUMBER: D21900	29d. DATE SIGNED (Month, Day, Year): 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Ho ~~8323 Hol~~ 7610 Carroll Ave TK PK Md. 20912

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23727

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Herbert Goodson, Sr.
2. DATE OF DEATH (Month, Day, Year): 9 28 89
3. TIME OF DEATH: 6 30 A M
4. SOCIAL SECURITY NUMBER: 408-03-8171
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Apr. 30, 1914
8. BIRTHPLACE (State or Foreign Country): Tennesse
9a. FACILITY NAME (If not institution, give street and number): 1700 Meridene Drive #505
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: ----------

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ----------
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1700 Meridene Drive #505
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years — College (1-4 or 5+): ----------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager
16b. KIND OF BUSINESS/INDUSTRY: Newspaper
17. FATHER'S NAME (First, Middle, Last): Henry Herbert Goodson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Mae Crews
19a. INFORMANT'S NAME (Type/Print): Myrtle L. Goodson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1700 Meridene Dr. Baltimore, Maryland 21239
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gar.
20c. LOCATION — City or Town, State: Timonium, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William E. Johnson
22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	several months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Rheumatic Heart disease with stenosis and insufficiency	years
DUE TO (OR AS A CONSEQUENCE OF): c.	Chronic Atrial fibrillation	years
DUE TO (OR AS A CONSEQUENCE OF): d.	Arteriosclerotic peripheral vascular disease	years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.
29c. LICENSE NUMBER: D00-383
29d. DATE SIGNED (Month, Day, Year): ▶ Sept 2nd 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3007 E. Northern Parkway Baltimore, Maryland 21214
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23728

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BLANCHE GAINES				2. DATE OF DEATH (Month / Day / Year): 09 / 01 / 89	3. TIME OF DEATH: 3:36p M
4. SOCIAL SECURITY NUMBER: 216-09-5622	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3/30/26	8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1826 RUTLAND AVENUE		10f. ZIP CODE: 21213		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY: HOUSEWIFE	
17. FATHER'S NAME (First, Middle, Last): NICHOLAS MARKS		18. MOTHER'S NAME (First, Middle, Maiden Surname): ZERA			
19a. INFORMANT'S NAME (Type/Print): RICHARD GAINES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1926 N. RUTLAND AVENUE/BALTIMORE, MD 21213			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK		20c. LOCATION — City or Town, State: ARBUTUS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Blaine Warner		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arrythmia	30 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	24 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: End stage renal failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jonathan Schlossstein MD		▶ 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JONATHAN SCHLOSSSTEIN 600 N WOLFE ST BALT MD 21205

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23729

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 of 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by ME 20

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH U. GREENSTEIN				2. DATE OF DEATH (Month, Day, Year): 8-30-89	3. TIME OF DEATH: 1.40 P M
4. SOCIAL SECURITY NUMBER: 217-09-3701	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 8, 1903	8. BIRTHPLACE (State or Foreign Country): Poland
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6530 Democracy Boulevard		10f. ZIP CODE: 20817	10g. CITIZEN OF WHAT COUNTRY? United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4 Years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pharmacist	16b. KIND OF BUSINESS/INDUSTRY: Drugs
17. FATHER'S NAME (First, Middle, Last): Julius Greenstein		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah (unascertainable)	
19a. INFORMANT'S NAME (Type/Print): Lee J. Greenstein		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11401 Rouen Drive, Potomac, Maryland 20854	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beth Sholom Congregation Cemetery	20c. LOCATION — City or Town, State: Capitol Heights, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein		22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. congestive heart failure	13 hr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. coronary heart disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: asthma

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James H Bradsky MD	29c. LICENSE NUMBER: D-20297	29d. DATE SIGNED (Month, Day, Year): ▶ 8-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James H. Bradsky, MD 4701 Willard Ave, Chevy Chase MD 20815

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Grandelle

OHMH-18 Rev 1/89

89 23730

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louise Hargett			2. DATE OF DEATH (Month, Day, Year): 08 31 89	3. TIME OF DEATH: 0916 AM
4. SOCIAL SECURITY NUMBER: 250-34-3161	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 07-18-24	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): Balto Co General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 4643 MANOR DONE		10f. ZIP CODE: 21229		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Thomas Magwood			18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan	
19a. INFORMANT'S NAME (Type/Print): Dorothy Thompson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9911 Winands Road		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR		20c. LOCATION — City or Town, State: Baltimore
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm Brown		22. NAME AND ADDRESS OF FACILITY: 1206 W. North Avenue		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertensive Cardiovascular Disease	18yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Percival E. Smith, M.D.	A51526322	▶ 9-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2600 Liberty Hghts Ave Baltimore, Md 21215

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23731

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS E. HALL				2. DATE OF DEATH: MONTH 9 DAY 2 YEAR 89	3. TIME OF DEATH: 7:45A.m. M
4. SOCIAL SECURITY NUMBER: 705-09-0099	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): 10/16/08	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Woodlawn		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 7139 Fairbrook Rd.		10f. ZIP CODE: 21207		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pipe Fitter		16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Louis Hall		18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Unknown			
19a. INFORMANT'S NAME (Type/Print): Warren E. Hall		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7139 Fairbrook Rd. Baltimore, Md. 21207			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Poplar Springs Cemetery		20c. LOCATION — City or Town, State: Woodbine, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L Goff		22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE CARDIOPULMONARY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. MYOCARDIAL INFARCTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CORONARY ARTERY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAROTID STENOSIS c TRANSIENT ISCHEMIC ATTACKS (AMAUROSIS)
BPH c CHRONIC PROSTATITIS c CA
DIFFUSE ARTERIOSCLEROSIS OBLITERANS, OSTEOARTHRITIS

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Soon Kim, MD	29c. LICENSE NUMBER: D22832	29d. DATE SIGNED (Month, Day, Year): ▶ 9/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Soon Kim 5808 Main Street Elkridge, Maryland 21227		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23732

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY SCOTT HOUCK
2. DATE OF DEATH: MONTH 9 DAY 2 YEAR 89
3. TIME OF DEATH: 1915 M
4. SOCIAL SECURITY NUMBER: 215-09-8918
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month) Day, Year): 12/12/05
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 823 Unetta Avenue
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Heavy Equip. Operator
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): William T. Houck
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Hale
19a. INFORMANT'S NAME (Type/Print): Michael S. Armiger
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 722 S. Hanover Street Baltimore, Md. 21230
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jackie D. Shannon
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 21229, 4107 Wilkens Avenue Baltimore, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Edmund P. Kaunitz MD
29c. LICENSE NUMBER: D34951
29d. DATE SIGNED (Month, Day, Year): 9/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3350 Wilkens Ave Suite 308 Balt MD 21229
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Items:7,9a,16b per FH G-656
10-30-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23733 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles F. Hessler			2. DATE OF DEATH (Month, Day, Year): 9-4-89	3. TIME OF DEATH: 5:10 P. M
4. SOCIAL SECURITY NUMBER: 215-28-6279	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): ~~5-22-1931~~ 5-2731	8. BIRTHPLACE (State or Foreign Country): Balto. MD.
9a. FACILITY NAME (If not institution, give street and number): 4450 Buck School House Road		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Co. Md. 21237		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4450 Bucks School House Road		10f. ZIP CODE: 21237	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8+): 2 yrs.	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant		16b. KIND OF BUSINESS/INDUSTRY: Mercantile ~~Equitable~~ Bank & Trust
17. FATHER'S NAME (First, Middle, Last): FRank G. Hessler		18. MOTHER'S NAME (First, Middle, Maiden Surname): EDwardine FRanz
19a. INFORMANT'S NAME (Type/Print): Ralph P. Hessler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Amesbury Court Cockeysville,Md.-21030
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith CEmetery	20c. LOCATION — City or Town, State: Baltimore,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy	22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc.	6415 BElair Road Baltimore,Md.-21206

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchogenic Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. R Lung

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] ~~NO~~	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] ~~NO~~

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Hawthorne MD	29c. LICENSE NUMBER: D07430	29d. DATE SIGNED (Month, Day, Year): ▶ 9/5/87
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23734

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES HOWARD
2. DATE OF DEATH: MONTH 08 DAY 28 YEAR 89
3. TIME OF DEATH: 330/pm M
4. SOCIAL SECURITY NUMBER: 213-61-1614
5. SEX: XX 1 M 2 F
5. AGE (In yrs. last birthday): 77 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 22, 1911
6. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville Hospital
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: Prince George's Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Jessup
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7245 Cedar Ave.
10f. ZIP CODE: 20794
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed
16b. KIND OF BUSINESS/INDUSTRY: General Contractor
17. FATHER'S NAME (First, Middle, Last): James E. Howard
18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie A. Gardner
19a. INFORMANT'S NAME (Type/Print): Edna Howard
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7245 Cedar Ave. Jessup, Maryland 20794
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Cemetery
20c. LOCATION — City or Town, State: Laurel Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary L Sollers
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Respiratory Arrest

DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Fibrosis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23735 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WOODWARD, ARTHUR HOBBS
2. DATE OF DEATH (Month, Day, Year): 08 28 89
3. TIME OF DEATH: 3:50 PM
4. SOCIAL SECURITY NUMBER: 219-05-4877
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/18/09
8. BIRTHPLACE (State or Foreign Country): Balto. Md.
9a. FACILITY NAME (If not institution, give street and number): FALLSTON GEN HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON, MD
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Harford Co.
10c. CITY, TOWN OR LOCATION: Belair
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 19 Bonnie Ave.
10f. ZIP CODE: 21014
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 8+): Md. Institute
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Rtd. Opertion Ser. Director
16b. KIND OF BUSINESS/INDUSTRY: Martin Marietta
17. FATHER'S NAME (First, Middle, Last): William H. Woodward
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Hobbs
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy E. Woodward
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 Bonnie Ave. Belair, Md. 21014
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Belair Mem. gardens
20c. LOCATION — City or Town, State: Bel Air, Md. 21014
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: E. F. Lassahn
22. NAME AND ADDRESS OF FACILITY: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest

DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD. Renal failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Malnutrition

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hobbs Last multiple med

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D-16444
29d. DATE SIGNED (Month, Day, Year): 8-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2112 Belair Rd. Fallston, Md Dr. Nair

31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23736

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annie Howell				2. DATE OF DEATH: MONTH 9 DAY 1 YEAR 89	3. TIME OF DEATH: 9 16 P M
4. SOCIAL SECURITY NUMBER: 212 26 5425	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): DEC. 20, 1928	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4537 PIMLICO ROAD		10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY? U. S. OF A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 - 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NURSES AID	16b. KIND OF BUSINESS/INDUSTRY: HOSPITAL			
17. FATHER'S NAME (First, Middle, Last): WILLIE E. TISDALE		18. MOTHER'S NAME (First, Middle, Maiden Surname): SYLVIA LEE			
19a. INFORMANT'S NAME (Type/Print): MR. FRED HOWELL, SR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4537 PIMLICO ROAD BALTIMORE, MARYLAND 21215			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY 9/7/89		20c. LOCATION — City or Town, State: BALTIMORE, MD. BALTO. CO.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lewis T. Gwynn		22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anoxic encephalopathy	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Respiratory arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Acute pulmonary edema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Myocardial infarction	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Deborah Morris MD		9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 10219 So. Dolfield Rd. Owings Mills, MD 21117

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23737

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Warren Donald Jones
2. DATE OF DEATH: MONTH 8 DAY 29 YEAR 89
3. TIME OF DEATH: 8:47 AM
4. SOCIAL SECURITY NUMBER: 219-28-1634
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 54 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/17/34
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 607 WYANOKE AVENUE
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COAST GUARD
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): ALVIN JONES
18. MOTHER'S NAME (First, Middle, Maiden Surname): GLADYS NATER Jones
19a. INFORMANT'S NAME (Type/Print): JOEANN JONES
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 CLIFTVIEW AVENUE/BALTIMORE, MD 21213
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM
20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warren
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. IMMUNOCOMPROMISE probable Sepsis
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Lung Cancer with bone Met
DUE TO (OR AS A CONSEQUENCE OF):
c. TOBACCO Use
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD
HEAVY Alcohol use
SMOKER - TOBACCO

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. Maldonado Brem MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ADRIANA MALDONADO-BREM
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23738 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HILARY AUGUST JONES			2. DATE OF DEATH (Month, Day, Year): 08/31/89	3. TIME OF DEATH: 0755 M
4. SOCIAL SECURITY NUMBER: 220-38-5399	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/12/12	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Catonsville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 611 Olesmont Road		10f. ZIP CODE: 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Brush Handle		16b. KIND OF BUSINESS/INDUSTRY: Factory
17. FATHER'S NAME (First, Middle, Last): Otho Jones		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Smith		
19a. INFORMANT'S NAME (Type/Print): Norman Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 Olesmont Road Baltimore, Md. 21228		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery		20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond Peterson		22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	BASAL CELL CA of larynx	5 years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Bilateral pleural effusion pneumonia ?	4 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ralph Alhalel M.D	29c. LICENSE NUMBER: St. Agnes	29d. DATE SIGNED (Month, Day, Year): 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RALPH ALHALEL 900 Caton Ave St. Agnes Hosp.		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

ONMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23739
REG. NO.

12+1

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Oates C. Keesecker			2. DATE OF DEATH (Month, Day, Year): 8-- 28 - 1989	3. TIME OF DEATH: 0800 a.m
4. SOCIAL SECURITY NUMBER: 236 22 5061	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 18, 1922	8. BIRTHPLACE (State or Foreign Country): Martinsburg, W. Va.
9a. FACILITY NAME (If not institution, give street and number): 12944 Harford Road		9b. CITY, TOWN OR LOCATION OF DEATH: Hydes	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Hydes	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 12944 Harford Rd.	10f. ZIP CODE: 21082	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Researcher	16b. KIND OF BUSINESS/INDUSTRY: Martin Marietta	
17. FATHER'S NAME (First, Middle, Last): Clifford H. Keesecker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Pitzer	
19a. INFORMANT'S NAME (Type/Print): Mrs. Lillian M.Keesecker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12944 Harford Rd. Hydes, Maryland 21082	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HighviewMem.Park	20c. LOCATION — City or Town, State: Fallston , Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn		22. NAME AND ADDRESS OF FACILITY: E.F.Lassahn Funeral Home 11750 Belair Rd.Kingsville,Md. 21087	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Diabetes Mellitus	Unknown
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Deputy Medical Exam.	29c. LICENSE NUMBER: D01085	29d. DATE SIGNED (Month, Day, Year): ▶ August 29, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stanley Z. Felsenberg M.D. 11 E. Chase Street 21202

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23740
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY Mary C. Claire Lauterbach LAUTER BACH				2. DATE OF DEATH (Month, Day, Year): 8 30 89	3. TIME OF DEATH: 8:40 P M
4. SOCIAL SECURITY NUMBER: 215-05-4559	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug 15, 1900	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Joseph's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Balto. Co.	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Cockeysville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 2 Hillary Way		10f. ZIP CODE: 21030		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Homemaking	
17. FATHER'S NAME (First, Middle, Last): Jessie Beaumont Lee		18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Broadwater Kinnear			
19a. INFORMANT'S NAME (Type/Print): Mrs. Rita L. Heavrin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Hillary Way, Cockeysville, Maryland 21030			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery		20c. LOCATION — City or Town, State: Parkville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson		22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Road, Timonium, MD 21093			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. DIABETIC KETOACIDOSIS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. END STAGE CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D33215
29d. DATE SIGNED (Month, Day, Year): ▶ 08/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

Item#6 Film#g655 09/08/89 da per F.H.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23741 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
ALFRED	GEORGE	MERTZ	Sept. 1, 1989	9:30 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
212-07-3948	1 [X] M 2 [ ] F	~~73~~ 74 YRS.			May 26, 1915	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Saint Joseph Hospital	Towson	Baltimore County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore County	Parkville	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
8018 Hillendale Road	21234	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO — WW II	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 8+)		
7 Years	--------	Cabinetworker	Furniture

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Frederick Mertz	Pauline Weinblinker

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pansy Maybine Mertz	8018 Hillendale Rd. Baltimore, MD 21234

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	Moreland Memorial Park	Baltimore Co., MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
William E. Johnson	William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Brain Death	5 min
	DUE TO (OR AS A CONSEQUENCE OF): b. Cardiopulmonary Arrest	5 min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): c. Squamous Cell Carcinoma of Lung	
	DUE TO (OR AS A CONSEQUENCE OF): d. Chronic Obstructive Pulmonary Disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [/] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [/] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] — House Physician	D38559-MD	9-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
Thomas J. [illegible] MD 6525 Banbury Rd Baltimore MD 21239

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23742

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH FRANKLIN MCBRIDE		2. DATE OF DEATH (Month, Day, Year): Sept. 01 1989	3. TIME OF DEATH: 110 AM M
4. SOCIAL SECURITY NUMBER: 198.16.1932	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 29, 1922
8. BIRTHPLACE (State or Foreign Country): New York			
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE	9c. COUNTY OF DEATH: A.A. COUNTY	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1114 Armistead Street	10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): –	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electronics Engineer	16b. KIND OF BUSINESS/INDUSTRY: Westinghouse
17. FATHER'S NAME (First, Middle, Last): Robert McBride		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alta Cleveland	
19a. INFORMANT'S NAME (Type/Print): Jean McBride		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Baltimore, Maryland 21229	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. George Hopkins		22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. HEPATIC FAILURE	2 WKS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CIRRHOSIS OF LIVER	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
INCARCERATED UMBILICAL HERNIA. SMALL BOWEL GANGRENE; INTRA-CEREBRAL BLEEDING

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Nepomuceno M.D.	29c. LICENSE NUMBER: D#16445	29d. DATE SIGNED (Month, Day, Year): ▶ 9-1-89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSE P. NEPOMUCENO, M.D. 7845 OAKWOOD ROAD, #107 GLEN BURNIE, MARYLAND 21061		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REDISTRAR'S SIGNATURE: [illegible]	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

Item 6 corrected per F.H. 9/6/89 mch

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23743

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
IRENE V. MOORE	AUGUST 30 1989	4:30 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-16-1363	1 ☐ M 2 ☒ F	~~72~~ 77 YRS.			2/22/12	W. VA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
THE JOHNS HOPKINS HOSPITAL	BALTIMORE CITY	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD		BALTIMORE	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1000 DARLEY AVENUE	21218	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	DOMESTIC	NA

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN GAINES	MARY KNIGHT

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BERTHA CARTER	1000 DARLEY AVENUE/BALTIMORE, MD 21218

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	KING MEMORIAL PARK	RANDALLSTOWN, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Calvin L. Williams	WM. C. MARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS.	<48°
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTATIC COLON CA (ADENO)	DIAGNOSIS 1 yr ago
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Sean P. Gaine MD		▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SEAN P. GAINE MD JOHNS HOPKINS HOSPITAL

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
8 SEP 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23744 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEO JOSEPH MELENOSKI, SR.		2. DATE OF DEATH (Month, Day, Year): 9 01 89	3. TIME OF DEATH: 8:30A.M. M
4. SOCIAL SECURITY NUMBER: 182-16-5201	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 9/14/22
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): 944 Regina Drive	9b. CITY, TOWN OR LOCATION OF DEATH: Arbutus	9c. COUNTY OF DEATH: Baltimore	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Arbutus	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 944 Regina Drive	10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tech.	16b. KIND OF BUSINESS/INDUSTRY: Telephone Co.	
17. FATHER'S NAME (First, Middle, Last): Peter Melenoski	18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Ryan		
19a. INFORMANT'S NAME (Type/Print): Janet R. Harshman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1506 Boggs Rd. Forest Hill, Md. 21050		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Brain Metastases / Carcinomatosis	6 wks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Small cell lung cancer	18 mo
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William C Waterfield MD	29c. LICENSE NUMBER: 024356	29d. DATE SIGNED (Month, Day, Year) ▶ 9/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Waterfield St. Agnes Hosp. Oncology Dept. Baltimore, Md.		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23745

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frieda E. Maier				2. DATE OF DEATH: MONTH 9 DAY 2 YEAR 89	3. TIME OF DEATH: 4:20 pM
4. SOCIAL SECURITY NUMBER: 215-03-6897	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 101 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-16-87	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson N. H.			9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Balto.
RESIDENCE OF DECEDENT					
10a. STATE: Md.	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Sparks			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 14035 Thorton Mill Rd.		10f. ZIP CODE: 21152		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dressmaker		16b. KIND OF BUSINESS/INDUSTRY: Clothing Mfg.	
17. FATHER'S NAME (First, Middle, Last): Louis Schaub			18. MOTNER'S NAME (First, Middle, Maiden Surname): Louisa Holzen		
19a. INFORMANT'S NAME (Type/Print): Marguerite M. Lake		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14035 Thorton Mill Rd.,Sparks, Md. 21152			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery		20c. LOCATION — City or Town, State: Balto.,Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John A Slonde		22. NAME AND ADDRESS OF FACILITY: 4905 York Rd. H. W. Jenkins & Sons Co.,Balto.,Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Generalized Atherosclerosis	years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: #to of Peptic Ulcer = GI bleed

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Sheldon Goldgeier	DO 2397	▶ Sept 5, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): sheldon Goldgeier M.D. 711 W. 40th St.,Balto.,Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23746 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WINFORD Allen MULLIS				2. DATE OF DEATH (Month, Day, Year): AUGUST 30 1989	3. TIME OF DEATH: 9:22A M
4. SOCIAL SECURITY NUMBER: 244-22-4440	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 6, 1923	8. BIRTHPLACE (State or Foreign Country): Ashe, N. Carolina
9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA	9c. COUNTY OF DEATH: CHARLES

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Nanjemoy	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 1, Box 94J		10f. ZIP CODE: 20662	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II US Army	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Presser	16b. KIND OF BUSINESS/INDUSTRY: Dry Cleaning	
17. FATHER'S NAME (First, Middle, Last): Charlie Mullis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lura May	
19a. INFORMANT'S NAME (Type/Print): Faye Woodie		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as Item 10a-10f	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Jefferson City Cemetery	20c. LOCATION — City or Town, State: Jefferson, N. Carolina	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00690 Howard A Causon		22. NAME AND ADDRESS OF FACILITY: Badger Whittamore Funeral Home 28694 300 Main Street, West Jefferson, N. Carolina	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D14864	29d. DATE SIGNED (Month, Day, Year): 5/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VA MC. DC 20422		Washington, D.C. 20422 Veteran's Administration Medical Center
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR ELEANOR E. MARSTON

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23747

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eleanor E. Marston		2. DATE OF DEATH (Month, Day, Year): 8 - 30 - 89	3. TIME OF DEATH: 12:30 P.M.
4. SOCIAL SECURITY NUMBER: 213-34-8040	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2-17-97
8. BIRTHPLACE (State or Foreign Country): Alabama			
9a. FACILITY NAME (If not institution, give street and number): Sharon Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Olney, MD.	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: OLNEY	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 18201 MARDEN LANE	10f. ZIP CODE: 20832	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 3	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NURSE	16b. KIND OF BUSINESS/INDUSTRY: NURSING	
17. FATHER'S NAME (First, Middle, Last): WILLIE ELLIOTT	18. MOTHER'S NAME (First, Middle, Maiden Surname): IRENE WILLIAMS		
19a. INFORMANT'S NAME (Type/Print): CARL E. HOWE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18510 MARDEN LANE OLNEY, MD. 20832		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LAYTONSVILLE	20c. LOCATION — City or Town, State: LAYTONSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Muriel H. Barber	22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. ADENOCARCINOMA OF THE COLON	3 WEEKS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BREAST CANCER
CORONARY ARTERY DISEASE
ANEMIA

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Fields MD ATTENDING PHYSICIAN	29c. LICENSE NUMBER: D34740 (MD)	29d. DATE SIGNED (Month, Day, Year): 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT FIELDS, MD; 18111 PRINCE PHILIP DR, T-12; OLNEY, MD 20532

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: John Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23748 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THELMA V. (MARSHALL) Marshall

2. DATE OF DEATH (Month, Day, Year): August 30, 1989

3. TIME OF DEATH: 0615 M

4. SOCIAL SECURITY NUMBER: 220-52-7792

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 86 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 1/12/03

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury

9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Somerset

10c. CITY, TOWN OR LOCATION: Crisfield, MD

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 327 Somers Cove Apts.

10f. ZIP CODE: 21817

10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 7 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife

16b. KIND OF BUSINESS/INDUSTRY: - - - -

17. FATHER'S NAME (First, Middle, Last): Oscar H. Smith

18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Charnick

19a. INFORMANT'S NAME (Type/Print): Eileen Tull

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Hayman's Drive - Princess Anne, MD 21853

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Tylerton Church Cemetery

20c. LOCATION — City or Town, State: Tylerton, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert N. Bradshaw Jr

22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac asystole	8/30/89
DUE TO (OR AS A CONSEQUENCE OF): b.	myocardial infarction	8/28/89
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Coronary + Generalized atherosclerosis	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: s/p coronary Artery By pass, Sick Sinus Syndrome, poly myalgia Rheumatica, old CVA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — **28b. TIME OF INJURY** M — **28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO — **28d. DESCRIBE HOW INJURY OCCURED**

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — **28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Saggar MD

29c. LICENSE NUMBER: D-18614

29d. DATE SIGNED (Month, Day, Year): 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DEEPAK SAGGAR 547E RIVERSIDE DRIVE SALISBURY, MD. 21801

31. DATE FILED (Month, Day, Year): SEP 5 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 23749

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MINNIE NICHOLS		2. DATE OF DEATH (Month, Day, Year): 9 01 89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 247-50-4974	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-5-07
8. BIRTHPLACE (State or Foreign Country): S.C.			
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN NURSING HOME	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD	9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1625 ARGONNE DRIVE	10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): EDGAR MURPHY	18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSANNA MURPHY		
19a. INFORMANT'S NAME (Type/Print): MELVINA YOUNG	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1625 ARGONNE DRIVE/BALTIMORE, MD 21218		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEMETERY	20c. LOCATION — City or Town, State: OWINGS MILLS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams	22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Seizure disorder	Few yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CVA:	14 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Diabetes Mellitus and ASCVD	7 yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dehydration and diarrheas

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M H Chung MD.	29c. LICENSE NUMBER: D 14745	29d. DATE SIGNED (Month, Day, Year): Sept. 1, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Myung H. Chung, M.D. 5670 The Alameda, Baltimore, Md. 21239		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23750
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas Nelson				2. DATE OF DEATH (Month, Day, Year): 08 01 89	3. TIME OF DEATH: 1:30 PM
4. SOCIAL SECURITY NUMBER: 247-20-2486	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-15-12	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY:		10c. CITY, TOWN OR LOCATION: Baltimore City		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2544 W. Lafayette Ave.			10f. ZIP CODE: 21216		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer Machinist		16b. KIND OF BUSINESS/INDUSTRY: Textile
17. FATHER'S NAME (First, Middle, Last): Madison Nelson			18. MOTHER'S NAME (First, Middle, Maiden Surname): C Lemmon		
19a. INFORMANT'S NAME (Type/Print): Dorothy Nelson			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2544 W. Lafayette Ave. 21216		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet Cem.		20c. LOCATION — City or Town, State: Balto. County
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Carlton C. Douglas			22. NAME AND ADDRESS OF FACILITY: 1701 McCulloh St. 21217		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. miliary tuberculosis

DUE TO (OR AS A CONSEQUENCE OF):

c. MAlnutrition

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

s/p whipple's procedure — carcinoma of pancreas

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C O'Kearney MD

29c. LICENSE NUMBER: D27860

29d. DATE SIGNED (Month, Day, Year): ▶ 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHRISTOPHER D. KEARNEY 700 WASH BLVD BALT MD 21230

31. DATE FILED (Month, Day, Year): SEP 5 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson Tingle

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23751
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 of 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETTIE C. PRIDGEN		2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 3, 1989	3. TIME OF DEATH: 10:23 A M
4. SOCIAL SECURITY NUMBER: 214-64-2235	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7/09/1894
8. BIRTHPLACE (State or Foreign Country): NC			
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1802 E. FEDERAL STREET	10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+):	15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED	16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): CHARLIE DAVIS		18. MOTHER'S NAME (First, Middle, Maiden Surname): DOLLIE	
19a. INFORMANT'S NAME (Type/Print): JOAN JOHNSON	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1802 E. FEDERAL STREET/BALTIMORE, MD 21213		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD NAT'L MEMORIAL PARK	20c. LOCATION — City or Town, State: LAUREL, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner	22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F?H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	1 WEEK
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. MALNUTRITION	1 YEAR
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. RENAL FAILURE	1 MONTH
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. BACTEREMIA WITH GROUP A STREPTOCOCCUS	1 WEEK

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CELLULITIS
DIFFUSE INTRAVASCULAR COAGULATION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Dustin Call MD		▶ SEPTEMBER 3, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID M. CROMWELL - JOHNS HOPKINS HOSPITAL DEPT. OF MEDICINE

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

ONMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23752
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Robert	People	8 / 31 / 89	7:45 P.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-01-5323	1 ☑ M 2 ☐ F	79 YRS.			JAN. 3, 1910	VA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
1038 N. Collington Avenue	Baltimore	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD.		BALTIMORE	1 ☑ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1038 N. COLLINGTON AVE.	21205	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ YES 2 ☐ NO — WW II	1 ☐ YES 2 ☑ NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
—	—	WAREHOUSEMAN	—

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Thomas PEOPIE	Alice Unknown

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CYNTHIA PEOPIE	925 N. BRADFORD ST. BALTO. MD. 21205

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	GARRISON FOR. VA CEMETERY	

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
David J. Weber	EDWARD J. WEBER 401 S. Chester St.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita McNeill	OCME	▶ 9-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Margarita A. Korell, M.D.	111 Penn St., Balto., Md. 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Thomas M. Pondell

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23753

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD PECK

2. DATE OF DEATH Month: 08 Day: 31 Year: 89

3. TIME OF DEATH: 1:55 AM M

4. SOCIAL SECURITY NUMBER: 219-30-0406

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 92 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): July 2, 1897

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Glen Burnie

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 318 Wellham Ave.

10f. ZIP CODE: 21061

10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 8+): College 4

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): teacher

16b. KIND OF BUSINESS/INDUSTRY: Baltimore City Public Schools

17. FATHER'S NAME (First, Middle, Last): Samuel Peck

18. MOTHER'S NAME (First, Middle, Maiden Surname): Cornelia Thomas

19a. INFORMANT'S NAME (Type/Print): Elizabeth Brooks

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 318 Wellham Ave. Glen Burnie, Maryland 21061

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathederal Cemetery

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L Collins

22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic prostate carcinoma — 2 years

DUE TO (OR AS A CONSEQUENCE OF): b. Bowel obstruction

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marc D. Sokolow Attending physician

29c. LICENSE NUMBER: D26534

29d. DATE SIGNED (Month, Day, Year) ▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Marc D. Sokolow M.D. 333 St. Paul Place Balto MD 21202

31. DATE FILED (Month, Day, Year): SEP 5 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23754

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BILL LILBERN PARHAM			2. DATE OF DEATH (Month, Day, Year): AUGUST 28 1989	3. TIME OF DEATH: 7:11 P M
4. SOCIAL SECURITY NUMBER: 561-54-8237	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 16 1914	8. BIRTHPLACE (State or Foreign Country): TEXAS
9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: VIRGINIA	10b. COUNTY: ARLINGTON	10c. CITY, TOWN OR LOCATION: ARLINGTON		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 3824 S. 12th STREET		10f. ZIP CODE: 22204		10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1932-1962	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 3	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSULTANT		16b. KIND OF BUSINESS/INDUSTRY: PRIVATE BUSINESS
17. FATHER'S NAME (First, Middle, Last): STITH ROLAND PARHAM		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANN PRESLEY		
19a. INFORMANT'S NAME (Type/Print): LOIS R. PARHAM		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3824 S. 12th STREET, ARLINGTON, VA 22204		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETERY		20c. LOCATION — City or Town, State: ARLINGTON, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: IVES-PEARSON FUNERAL HOMES ARLINGTON, VA. 22201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. STROKE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Philip Perdue M.D.	29c. LICENSE NUMBER: 16996 (Oklahoma)	29d. DATE SIGNED (Month, Day, Year) ▶ 30 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. PERDUE, LT, MC, USNR	NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20814-5011	
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23755

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ednamae Ring					2. DATE OF DEATH (Month / Day / Year): 9 / 1 / 89	3. TIME OF DEATH: 5:56 A.M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 02/06/28	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore			9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Anne Arundel	N. Linthicum	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
105 Charles Road	21090	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12): 12 yrs.	College (1-4 or 5+)	housewife	own home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles Wachter	Florence Mitchell

18a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Craig Ring	1700 Frederick Road Catonsville,Md. 21228

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Baltimore-Washington Crematory	Laurel, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
[signature]	Ambrose Funeral Home,Inc. 1328 Sulphur Spring Road 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 9-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Balto., Md. 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	[signature]

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23756

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTIE RUPPERT			2. DATE OF DEATH (Month, Day, Year): 09 02 '89	3. TIME OF DEATH: 4:15P M
4. SOCIAL SECURITY NUMBER: 214-20-4997	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-21-1899	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5604 Knell Avenue		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th GRade; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory	16b. KIND OF BUSINESS/INDUSTRY: Bendix Radio	
17. FATHER'S NAME (First, Middle, Last): Cornelius Asbury Martin		18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola James Williams	
19a. INFORMANT'S NAME (Type/Print): Hazel J. Fletcher		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5604 Knell Avenue Baltimore, Maryland-21206	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cem.	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy	22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc.	6415 Belair Road Baltimore, Md.-21206	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY CARDIAC ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ACUTE PULMONARY CONGESTION	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CEREBROVASCULAR STROKE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Noreen Rahat Hashmi MD		▶ 9-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. HASHMI, M.D. - GBMC - 6701 N. CHARLES ST. TOWSON, MD. 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23757

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SUZANNE SMITH (nee Rappold)
2. DATE OF DEATH: MONTH 08 DAY 31 YEAR 89
3. TIME OF DEATH: 7:13 p M
4. SOCIAL SECURITY NUMBER: 220-48-2531
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 33 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct 5, 1955
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CTR
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Lutherville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 227 Spring Avenue
10f. ZIP CODE: 21093
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Graphic Artist
16b. KIND OF BUSINESS/INDUSTRY: Film Production
17. FATHER'S NAME (First, Middle, Last): Daniel August Rappold
18. MOTHER'S NAME (First, Middle, Maiden Surname): Kathleen Mary Gleeson
19a. INFORMANT'S NAME (Type/Print): Mr. Gary Wayne Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6754 Tanglewood Bay Dr. Apt 413, Orlando, Fla. 32821
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory
20c. LOCATION — City or Town, State: Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, Md 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MASSIVE INTRACEREBRAL HEMORRHAGE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Vaginal delivery

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRISE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Beth R. Schwartz
29c. LICENSE NUMBER: D38352
29d. DATE SIGNED (Month, Day, Year): ▶ 09/01/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Beth R. Schwartz, M.D.; GBMC - 6701 N. Charles St; Towson, MD 21204
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23758

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Berniece V. Russell				2. DATE OF DEATH (Month, Day, Year): 8-29-89	3. TIME OF DEATH: 8:15 AM
4. SOCIAL SECURITY NUMBER: 217-78-9983	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-5-09	8. BIRTHPLACE (State or Foreign Country): Scott Co. Va.
9a. FACILITY NAME (If not institution, give street and number): Fallston Gen. Hos.		9b. CITY, TOWN OR LOCATION OF DEATH: Fallston		9c. COUNTY OF DEATH: Harford co.	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baldwin	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12906 Fork Rd.		10f. ZIP CODE: 21013	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Elbert Stallard		18. MOTHER'S NAME (First, Middle, Maiden Surname): Venice McClellan	
19a. INFORMANT'S NAME (Type/Print): Harry E. Russell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2860 Pocock Rd. Monkton, Md. 21111	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fork U. Meth. Ch. Cem.	20c. LOCATION — City or Town, State: Fork, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn		22. NAME AND ADDRESS OF FACILITY: E.F.Lassahn Funeral Home 11750 Belair Rd.Kingsville,Md.21087	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory/Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebro Vascular Accident	2 Mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: S/p broken hip

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Deputy Medical Examiner - Harford County		29c. LICENSE NUMBER: D31445	29d. DATE SIGNED (Month, Day, Year): ▶ 8-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 212 South Bond Bel Air, MD			
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23759

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GERALD WESLEY REEDER		2. DATE OF DEATH (Month, Day, Year): Sept. 02, 89	3. TIME OF DEATH: 1155 AM M
4. SOCIAL SECURITY NUMBER: 216-28-7018	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 4, 1900
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE	9c. COUNTY OF DEATH: A.A. COUNTY	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 309 Georgia Ave. N.E.		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W.II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th. College (1-4 or 5+): None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Captain	16b. KIND OF BUSINESS/INDUSTRY: U.S. Army
17. FATHER'S NAME (First, Middle, Last): Wallace C. Reeder		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Reynolds	
19a. INFORMANT'S NAME (Type/Print): Mrs. Amalia M. Reeder		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 Georgia Ave. N.E., Glen Burnie, Md. 21061	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Pk.	20c. LOCATION — City or Town, State: Glen Burnie, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. George Hopkins		22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Ave. S.W. Glen burnie, Maryland21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Hypoxic and Hypercapnic respiratory failure due to	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive lung disease DUE TO (OR AS A CONSEQUENCE OF):	years
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Arteriosclerosis Recent Stroke Hypercholesterolemia Myocardial Infarct Dementia Cardiac Arrhythmia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Po Hsu Hung, M.D.	29c. LICENSE NUMBER: D25000	29d. DATE SIGNED (Month, Day, Year): Sept. 2, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PO-HSLU HUNG, M.D. 325 HOSPITAL DRIVE, #108 GLEN BURNIE, MARYLAND 21061		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23760 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GERALDINE H. RAYMAN			2. DATE OF DEATH (Month, Day, Year): 9-2-89	3. TIME OF DEATH: 11:45 A
4. SOCIAL SECURITY NUMBER: 216-66-3840	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-11-1910	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3302 YORKWAY		10f. ZIP CODE: 21222		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced — X	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES X ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker		16b. KIND OF BUSINESS/INDUSTRY: Homemaker
17. FATHER'S NAME (First, Middle, Last): James Rytina			18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Hudecek	
19a. INFORMANT'S NAME (Type/Print): Milton Rayman		19b. ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip): 607 Kingston Rd. Balto., Md. 21220		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem	Baltimore Md,	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradlry Fh 2135 DDUndalk AVE Balto, md 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

			Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	SEPSIS	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Liver failure	LIVER FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF): c. Renal failure	RENAL FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin INSULIN DEPENDENT MELLITIS
Hypo thyroidism HYPO HYZROIDISM
Pernicious Anemia PERICIOUS ANEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D33184	9/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jonathan D. Kushner, MD — JONATHAN D. KUSHNER, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

UNKNOWN 89-157

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23761

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): David Keith Stevens			2. DATE OF DEATH (Month, Day, Year): 8-30-89	3. TIME OF DEATH: 10:12PM M
4. SOCIAL SECURITY NUMBER: 213-48-0051	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 27 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 14,1962	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 5047 Truesdale (rear)		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Arbutus		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 925 Leeds Avenue		10f. ZIP CODE: 21229		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist		16b. KIND OF BUSINESS/INDUSTRY: mfg.
17. FATHER'S NAME (First, Middle, Last): Alan D. Stevens			18. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley Ganley	
19a. INFORMANT'S NAME (Type/Print): Mrs. Shirley G. Stevens		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 925 Leeds Avenue Arbutus, Maryland 21227		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gds.		20c. LOCATION — City or Town, State: Towson, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road 21227		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wound to head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence XX Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-30-89	28b. TIME OF INJURY: PM M	28c. INJURY AT WORK? 1 [ ] YES XX NO
	28d. DESCRIBE HOW INJURY OCCURED: Subject shot		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): rear		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 5047 Truesdale, Baltimore City Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and dua to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. MD	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Mario F. Golle, Jr., M.D.	111 Penn Street, Baltimore, MD 21201	vc
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23762

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN J SETHERLY AKA: John J. Setherley, Jr.
2. DATE OF DEATH (Month, Day, Year): Sep. 3 89
3. TIME OF DEATH: 0847 M
4. SOCIAL SECURITY NUMBER: 215-22-3757
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/31/28
8. BIRTHPLACE (State or Foreign Country): Baltimore, Md.
9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Eldersburg
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6317 Georgetown Blvd. Apt. B
10f. ZIP CODE: 21784
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 yrs — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): warehouseman
16b. KIND OF BUSINESS/INDUSTRY: mfg.
17. FATHER'S NAME (First, Middle, Last): John J. Setherley, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred I. Thomas
19a. INFORMANT'S NAME (Type/Print): Corrine W. Setherley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6317 Georgetown Blvd. Eldersburg, Md. 21784
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery
20c. LOCATION — City or Town, State: Woodlawn, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiogenic Shock
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HIO ASCVD disease
Ventricular fibrillation

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Hafeez A Syed M.D
29c. LICENSE NUMBER: D25052
29d. DATE SIGNED (Month, Day, Year): ▶ 9/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HAFEEZ A SYED 20 Cross Roads Dr. Owings Mills Md 21117
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Julia Patterson

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23763 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William J Spicer
2. DATE OF DEATH — MONTH: 8 DAY: 25 YEAR: 89
3. TIME OF DEATH: 7:15 AM
4. SOCIAL SECURITY NUMBER: 219-18-0937
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/9/24
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): 2509 Ruscomb LA
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2509 Ruscomb Lane
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 1943-46
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dispather
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): William J. Spicer Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Jackson
19a. INFORMANT'S NAME (Type/Print): Lucinda Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2509 Ruscomb Lane Balto, MD. 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet. Cemetry
20c. LOCATION — City or Town, State: Owings Mills, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown
22. NAME AND ADDRESS OF FACILITY: 1206 W. North Ave William C. Brown Community F.H.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Rectal Carcinoma — 2yrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 9 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donald T Brown MD
29c. LICENSE NUMBER: D24149
29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Debra Tibbs Balto VA LR VAMC CH 11 3900 Loch Raven Blvd Baltimore 21218
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23764

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN SORRELL B.
2. DATE OF DEATH: MONTH 8 DAY 30 YEAR 1989
3. TIME OF DEATH: 11:30P M
4. SOCIAL SECURITY NUMBER: 219-22-2689
5. SEX: XX 1 M 2 ☐ F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04/08/1930
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Perry Point Veteran's Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Perryville
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 920 Franklintown Road
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: XX 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX 1 YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: 02/01/52 - 12/01/54
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled Veteran
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Joseph J. Sorrell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Henrietta Maddox

19a. INFORMANT'S NAME (Type/Print): Geraldine Guest
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1510 West Mosher St. Apt. MJ Balto, Maryland 21217

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veteran Cem.
20c. LOCATION — City or Town, State: Baltimore County, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R Perry Jr.
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XX NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 XX
26. PLACE OF DEATH (Check only one) — HOSPITAL: XX 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): X 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas E Finucan
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas Finucan M. D. VAMC Perry Point Md 21902
31. DATE FILED (Month, Day, Year): SEP 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23765

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAROLD Eugene Shaeffer

2. DATE OF DEATH (Month, Day, Year): August 27, 1989

3. TIME OF DEATH: 10:09P M

4. SOCIAL SECURITY NUMBER: 212-16-2105

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 71 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 09/19/1917

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Monkton

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 743 Monkton Road

10f. ZIP CODE: 21111

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 4

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist

16b. KIND OF BUSINESS/INDUSTRY: Aerospace

17. FATHER'S NAME (First, Middle, Last): William Shaeffer

18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Wyatt

19a. INFORMANT'S NAME (Type/Print): Edith S. Shaeffer

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 743 Monkton Road, Monkton, MD 21111

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pine Grove Cemetery

20c. LOCATION — City or Town, State: Parkton, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. J. Hartenstein

22. NAME AND ADDRESS OF FACILITY: J. J. Hartenstein Mortuary, Inc.
24 Second St., New Freedom, PA 17349

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebral embolism from — DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiac dysrhythmia — DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
c. — DUE TO (OR AS A CONSEQUENCE OF):
d. —

Sudden

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F O'Donnell

29c. LICENSE NUMBER: D-09383

29d. DATE SIGNED (Month, Day, Year): Aug 27 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F O'Donnell MD - 7501 York Rd Towson Md 21204

31. DATE FILED (Month, Day, Year): SEP 5 1989

32. REGISTRAR'S SIGNATURE: Gika Davidson-Kendall

DHMH-15 Rev 1/89

ITEM #10F FILM #G655 PER: F.H./J. A. 9/7/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23766 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Billy K Smith			2. DATE OF DEATH (Month, Day, Year): 9 7 89		3. TIME OF DEATH: 3:54 pm M
4. SOCIAL SECURITY NUMBER: 217-01-1872	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct 4, 1913
8. BIRTHPLACE (State or Foreign Country): North Carolina					
9a. FACILITY NAME (If not institution, give street and number): St. Joseph's Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore County
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Sparks			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 16701 Yeoho Road		10f. ZIP CODE: ~~21093~~ 21152			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager			16b. KIND OF BUSINESS/INDUSTRY: Wholesale Upholstry
17. FATHER'S NAME (First, Middle, Last): David Alexander Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence May Dunty			
19a. INFORMANT'S NAME (Type/Print): Marjorie Miller Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16701 Yeoho Road, Sparks, MD 21152			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Carmel U. Meth. Cemetery			20c. LOCATION — City or Town, State: Parkton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson, Martin D Lawson		22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cardiac or reepiratory arrest, ehock, or heart failure. List only one cause on eech line.

		Approximeta Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. LOW CARDIAC OUTPUT SYNDROME	
DUE TO (OR AS A CONSEQUENCE OF):	b. OPEN HEART SURGERY (REDO)	IMMEDIATE
Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF):	c. AORONARY ARTERY DISEASE, AORTIC VALVE	10 YRS
DUE TO (OR AS A CONSEQUENCE OF):	d. REGURGITATION	

PART II. Other significant conditions contributing to death but not raaulting in the underlying cause given in Part I.: CAROTID ARTERY DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Garth R McDonald attending Surgeon	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 9.1.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DEPT CARDIAC SURGERY SAINT JOSEPH HOSPITAL TOWSON MD		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Tewidem Tyndall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23767

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLAY REECE SUITT				2. DATE OF DEATH: MONTH 9 DAY 1 YEAR 89	3. TIME OF DEATH: 6 50 PM
4. SOCIAL SECURITY NUMBER: 212-32-4171	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 21, 1911	8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON		9c. COUNTY OF DEATH: HARFORD	
RESIDENCE OF DECEDENT					
10a. STATE: Md.	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 410 South Fountain Green Road		10f. ZIP CODE: 21014		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder		16b. KIND OF BUSINESS/INDUSTRY: Steel	
17. FATHER'S NAME (First, Middle, Last): Melvin Suitt		18. MOTHER'S NAME (First, Middle, Maiden Surname): Loye Pugh			
19a. INFORMANT'S NAME (Type/Print): Ruth Ann Ball		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2102 West Court Bel Air, Md. 21014			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jarrettsville Cemetery		20c. LOCATION — City or Town, State: Jarrettsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Benjamin W. Kurtz		22. NAME AND ADDRESS OF FACILITY: Kurtz Funeral Home P.O. BOX 6 Jarrettsville, Md. 21084			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. respiratory arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. congestive heart failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. renal failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. hypertic failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David S. Dunn MD	29c. LICENSE NUMBER: D32799	29d. DATE SIGNED (Month, Day, Year): ▶ 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1131 Belaire Rd DAVID S. DUNN		
31. DATE FILED (Month, Day, Year): SEP 15 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 SFT

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23768 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH FRANCIS SCHMITT, SR.		2. DATE OF DEATH (Month, Day, Year): September 2, 1989	3. TIME OF DEATH: 1523 M
4. SOCIAL SECURITY NUMBER: 220-24-1136	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 22, 1930
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie	9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 404 Glenmont Ave. (Ferndale)	10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korean	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 3 years	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Purchasing Manager	16b. KIND OF BUSINESS/INDUSTRY: Marlenn Corporation	
17. FATHER'S NAME (First, Middle, Last): Louis R. Schmitt	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary A. Neser		
19a. INFORMANT'S NAME (Type/Print): Mrs. Sara M. Schmitt	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 Glenmont Ave. (Ferndale) Glen Burnie, Md.21061		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Crownsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins	22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, Maryland21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Heart Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 5 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William P. Jones MD Deputy	29c. LICENSE NUMBER: D06054	29d. DATE SIGNED (Month, Day, Year): ▶ 9/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William P. Jones MD 1095 America 21035		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

DHMH-16 Rev 1/89

DFT

89 23769

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jake (NMN) Saiia			2. DATE OF DEATH (Month, Day, Year): Sept. 01 1989	3. TIME OF DEATH: 4:00 P M
4. SOCIAL SECURITY NUMBER: 213.34.8028	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 1, 1910
8. BIRTHPLACE (State or Foreign Country): Pennsylvania				
9a. FACILITY NAME (If not institution, give street and number): Kimbrough Army Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Fort Meade	9c. COUNTY OF DEATH: Anne Arundel		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO	
10e. STREET AND NUMBER: 303 Wende Way	10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance Engineer	16b. KIND OF BUSINESS/INDUSTRY: North Arundel Hospital		
17. FATHER'S NAME (First, Middle, Last): Pietro Saiia	18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Brigandi			
19a. INFORMANT'S NAME (Type/Print): Thelma Saiia	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10E			
20a. METHOD OF DISPOSITION: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Crownsville, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins	22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Colon Cancer	6 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Renovascular Hypertension
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Arthur B. Dalton, MD	US ARMY	▶ Sept. 1, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARTHUR B. DALTON MD KIMBROUGH ARMY Hospital Ft. Meade, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23770

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Henry Thiess a.k.a. (Henry John)

2. DATE OF DEATH Month: 9 Day: 1 Year: 89

3. TIME OF DEATH: 6 12 P M

4. SOCIAL SECURITY NUMBER: 220 12 4463

5. SEX: 1 X M 2 ☐ F

6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 1/28/14

8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): Baltimore VA Hospital Loch Raven

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD

9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: ----------

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO

10e. STREET AND NUMBER: 2835 Brendan Ave.

10f. ZIP CODE: 21213

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES: WW II

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 X NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): H.S.
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Paperhanger

16b. KIND OF BUSINESS/INDUSTRY: Decorating

17. FATHER'S NAME (First, Middle, Last): Henry L. Thiess

18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Slavin

19a. INFORMANT'S NAME (Type/Print): Anna J. Thiess

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2835 Brendan Ave., Balt., Md. 21213

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus

20c. LOCATION — City or Town, State: Dundalk, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00137

22. NAME AND ADDRESS OF FACILITY: John A. Moran, Inc. 3000 E. Balt. St. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	20 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Septic shock	7 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.	perforated diverticulitis	14 days
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): NA

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Baltimore Veterans Hospital

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John A Stevens MD Surg Resident

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Same

31. DATE FILED (Month, Day, Year): SEP 15 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23771

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Marcus	Joseph	Torrence	Sept. 2, 1989	5:00pM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-09-4725	X 1 M 2 F	72 YRS.			5-2-17	Md.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Church Hospital Corporation	Baltimore	----------

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	----------	Baltimore City	1 X YES 2 NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
204 N. LUzerne Ave.	21224	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 YES 2 X NO	1 YES 2 X NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
H.S.		Electrical repair	Steel Co.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William Torrence	Clara Richter

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Evelyn A. Torrence	204 N. Luzerne Ave., Balt., Md.,21224

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Suburban Crematory	Silver Spring, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature] M0177	John A. Moran, Inc. 21224 3000 E. Baltimore St., Balt., Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Liver Metastasis, Unknown primarily
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Liver metastasis, unknown primary
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis Sepsis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 X NO	1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 Natural 2 Accident 3 Suicide 4 Homicide 6 Pending investigation 8 Could not be determined		M	1 YES 2 NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J. Azar M.D. J. Azar M.D	D-36386	▶ 9/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89-23772

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23772

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frederick G. Winterling				2. DATE OF DEATH: MONTH 9 DAY 1 YEAR 89	3. TIME OF DEATH: 11:33 M
4. SOCIAL SECURITY NUMBER: 215-10-2445	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12/09/1895	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury		9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Berlin, Maryland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1 Meadow Street		10f. ZIP CODE: 21811	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 yrs; College (1-4 or 5+)	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Milkman	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Conrad Winterling		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jeny Buettner	
19a. INFORMANT'S NAME (Type/Print): Alberta Beard	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1614 Ocean Pines, Berlin, MD 21811		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem	20c. LOCATION — City or Town, State: Baltimore, md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Elizabeth Dowell	22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler, Inc. Funeral Home 1901 Eastern Ave. Balto., MD 21231		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cardio respiratory arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF OEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W B Stoner MD	29c. LICENSE NUMBER: D13053	29d. DATE SIONED (Month, Day, Year) ▶ 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Jane Barker Rodes

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23773

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALVIE INGRAM WEST				2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 3 1989	3. TIME OF DEATH: 9:35 A M
4. SOCIAL SECURITY NUMBER: 219 36 3521	5. SEX: 1 [X] M 2 [ ] F	5. AGE (In yrs. last birthday): 48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JAN. 22, 1941	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4406 LA PLATA AVENUE		10f. ZIP CODE: 21211	10g. CITIZEN OF WHAT COUNTRY?: U. S. OF A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 - 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TIREMAN	16b. KIND OF BUSINESS/INDUSTRY: GRIMES TIRE COMPANY	
17. FATHER'S NAME (First, Middle, Last): RAYMOND M. WEST		18. MOTHER'S NAME (First, Middle, Maiden Surname): VIVIAN ETTA BROWN	
19a. INFORMANT'S NAME (Type/Print): MRS. CATHERINE HARGIS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4406 LA PLATA AVENUE APT. J BALTIMORE, MARYLAND	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BARTONSVILLE CEMETERY 9/9/89	20c. LOCATION — City or Town, State: BARTONSVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lewis T Gwynn		22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione thet ceused the deeth. Do not enter the mode of dying, such se cerdiac or reepiratory arreat, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. exsanguination or progression	10 sec
DUE TO (OR AS A CONSEQUENCE OF):	b. dissection of thoracic aortic aneurysm	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. severe hypertension	years
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy C Buchman	29c. LICENSE NUMBER: D31894	29d. DATE SIGNED (Month, Day, Year): ▶ Sep 3 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TIMOTHY C. BUCHMAN		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23774

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Esther Fountaine Yeatts			2. DATE OF DEATH (Month, Day, Year): September 3, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 218.18.7051	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 23, 1923	8. BIRTHPLACE (State or Foreign Country): (Unknown)
9a. FACILITY NAME (If not institution, give street and number): 221 Woodhill Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 221 Woodhill Drive		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (Unknown)	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier (Ret)	16b. KIND OF BUSINESS/INDUSTRY: Food Store
17. FATHER'S NAME (First, Middle, Last): James T. Colburn		18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Blizzard	
19a. INFORMANT'S NAME (Type/Print): John A. Hoffman, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 Riverside Drive, Pasadena, Md. 21122	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Elkridge, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Avenue S.W., Glen Burnie, Md. 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MI	DUE TO (OR AS A CONSEQUENCE OF):	1 hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. Coronary Heart Disease	DUE TO (OR AS A CONSEQUENCE OF):	1 years
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: 17744	29d. DATE SIGNED (Month, Day, Year): ▶ 9/7/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23775

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Althea R. Wolford

2. DATE OF DEATH Month: 8 Day: 31 Year: 89

3. TIME OF DEATH: 9:10 P M

4. SOCIAL SECURITY NUMBER: 215-18-6709

5. SEX: 1 ☐ M 2 ☒ F

8. AGE (In yrs. last birthday): 74 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 05 09 15

6. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): 3142 Remington Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: ---

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: --

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 3142 REMINGTON AVENUE

10f. ZIP CODE: 21211

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife

16b. KIND OF BUSINESS/INDUSTRY: - -

17. FATHER'S NAME (First, Middle, Last): MARVIN B. PHILLIPS

18. MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE S. KNIGHT

19a. INFORMANT'S NAME (Type/Print): Shirely Leatherwood

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Timberleria Rd, San Antonio, Tex. 78250

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY

20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: A. Alan Seitz, Jr.

22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME
3818 ROLAND AVE. BALTIMORE, MD. 21211

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XX NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): 9-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Balto., Md. 21201

31. DATE FILED (Month, Day, Year): SEP 5 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Rendese

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-23776

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CARL Warfield WALKER					2. DATE OF DEATH (Month / Day / Year): 8 / 28 / 89	3. TIME OF DEATH: 1147A M
4. SOCIAL SECURITY NUMBER: 212-32-3929	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7/5/1903	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON		9c. COUNTY OF DEATH: HARFORD	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Jarrettsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3970 Old Federal Hill Road		10f. ZIP CODE: 21084	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4 or 5+): --	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Farming	
17. FATHER'S NAME (First, Middle, Last): Abram Baldwin Walker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Brookhart	
19a. INFORMANT'S NAME (Type/Print): Mildred V. Walker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jarrettsville Cemetery	20c. LOCATION — City or Town, State: Jarrettsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M. Gladden Kurtz III		22. NAME AND ADDRESS OF FACILITY: Kurtz Funeral Home Jarrettsville, Maryland 21084	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF): Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. [ ]

DUE TO (OR AS A CONSEQUENCE OF): Acute Myocardial Infarction

c. [ ]

DUE TO (OR AS A CONSEQUENCE OF):

d. [ ]

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew Vonrabenwald MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 125 N. MAIN ST BEL AIR, MD 21014

31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson Rinehart

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23777

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Elaine Andrews			2. DATE OF DEATH (Month, Day, Year): August 21, 1989	3. TIME OF DEATH: 7:58 A. M
4. SOCIAL SECURITY NUMBER: 212-54-8046	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05-30-1950	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 221 Springdale Street		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 221 Springdale Street		10f. ZIP CODE: 21502		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): beautician	16b. KIND OF BUSINESS/INDUSTRY: health care for elderly		
17. FATHER'S NAME (First, Middle, Last): Ervin Steinmetz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Bishop		
19a. INFORMANT'S NAME (Type/Print): Charles O. Andrews		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 221 Springdale Street, Cumberland, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park		20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio-Pulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatacic Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Carcinoma of the Breast	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D09157	▶ 8-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Paul Snow, M.D., Dept. Med. Ex., 124 W. Third Street, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 21 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23778

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
RUTH	W.	BEVANS	August 17, 1989	10:40 P.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
233-72-2541	1 ☐ M 2 ☒ F	91 YRS.			12-02-1897	WV

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital & Medical Center	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
WV	Hampshire	Paw Paw	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Box 92	25434	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		co-owner	general store

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles E. Wentling	Miranda Catherine Dickens

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Jane B. Slusher	2614 Kresson Place, Bowie, MD 20715

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St. Marys Cemetery	Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James F Scarpelli	Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Strokes & atrial fibrillation	
	c. DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D16041	▶ 8-17-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Terry Williams, Memorial Hospital Medical Building, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 22 1989	Julia Davidson-Henderson

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23779 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alma Mae Ciccanti		2. DATE OF DEATH (Month, Day, Year): Aug 18 1989	3. TIME OF DEATH: 10:14 a M
4. SOCIAL SECURITY NUMBER: 218-24-8139	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04-05-1927
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): Sacred Heart Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: LaVale	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 538 B Street	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): Reese I. Hardman	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille M. Wineland		
19a. INFORMANT'S NAME (Type/Print): Reynold A. Ciccanti	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 538 B Street, LaVale, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hyndman Cemetery	20c. LOCATION — City or Town, State: Hyndman, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction — 5 minutes

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. hypertensive and arteriosclerotic heart disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Giovanni Mastrangelo Dep. Med. Exam.	29c. LICENSE NUMBER: D07098	29d. DATE SIGNED (Month, Day, Year): 8-18-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Giovanni Mastrangelo, M.D., 900 Seton Drive, Cumberland, MD 21502		
31. DATE FILED (Month, Day, Year): AUG 22 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23780 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lloyd W. Diehl
2. DATE OF DEATH: MONTH 08 DAY 15 YEAR 89
3. TIME OF DEATH: 9:09 A M
4. SOCIAL SECURITY NUMBER: 173-18-1588
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05/23/1908
8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Lions Manor Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: PA
10b. COUNTY: Bedford
10c. CITY, TOWN OR LOCATION: Hyndman
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: R D 1, Box 436
10f. ZIP CODE: 15545
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner/ Operator
16b. KIND OF BUSINESS/INDUSTRY: Service Station
17. FATHER'S NAME (First, Middle, Last): Newton Diehl
18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Lohr
19a. INFORMANT'S NAME (Type/Print): Carolyn M. Diehl
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R D 1, Box 436, Hyndman, PA 15545
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☒ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park
20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harvey H. Zeigler
22. NAME AND ADDRESS OF FACILITY: Harvey H. Zeigler Funeral Home, Clarence Street, Hyndman, PA 15545

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Septicemia.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic U.T.I & pyelonephritis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Obstructive uropathy.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(1) Severe Parkinson's disease
(2) Arterio sclerotic peripheral Vascular disease.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: V. A. Ranjithan
29c. LICENSE NUMBER: D19750
29d. DATE SIGNED (Month, Day, Year): ▶ 08-15-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. A. Ranjithan, M.D. LMNH Seton Drive Ext. Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): AUG 17 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

7

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23781
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD CHRISTOPHER DYCHE					2. DATE OF DEATH (Month, Day, Year): August 13, 1989		3. TIME OF DEATH: 12:35 A_M
4. SOCIAL SECURITY NUMBER: 220-10-8764	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-11-1914		8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland			9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT							
10a. STATE: MD	10b. COUNTY: Allegany		10c. CITY, TOWN OR LOCATION: Cumberland			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 848 Gephart Drive			10f. ZIP CODE: 21502			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired clerk			16b. KIND OF BUSINESS/INDUSTRY: U.S. Postal Service	
17. FATHER'S NAME (First, Middle, Last): Clarence R. Dyche, Sr.					18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie May Shultz		
19a. INFORMANT'S NAME (Type/Print): James R. Dyche III			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 848 Gephart Drive, Cumberland, MD 21502				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rocky Gap Veterans Cemetery			20c. LOCATION — City or Town, State: Flintstone, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli			22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, Cumberland, MD 21502				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): Pulmonary CA of LTS

c. DUE TO (OR AS A CONSEQUENCE OF): Renal Failure

d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D16041

29d. DATE SIGNED (Month, Day, Year): ▶ 8-15-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. T. Williams Memorial Hospital Medical Building, Cumberland, MD. 21502

31. DATE FILED (Month, Day, Year): AUG 17 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

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DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23782

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CARL NELSON FIELD				2. DATE OF DEATH (Month, Day, Year): 8-19-89	3. TIME OF DEATH: 6:05A M
4. SOCIAL SECURITY NUMBER: 217057273	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-16-1910	8. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 2 Box 800 Hazen Road		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ret. engineer	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Watson E. Field		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Phillips	
19a. INFORMANT'S NAME (Type/Print): Elnora L. Field		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2 Box 800, Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. (1) Respiratory failure — (2) Hyperkalemia	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): (2) COPD — severe Mitral stenosis & Pulmonary HTN (1) CHF	
	c. DUE TO (OR AS A CONSEQUENCE OF): CRF + BPH c obstruction	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe COPD c Bullous emphysema
Recurrent Pneumothorax

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: V Felipa MD	29c. LICENSE NUMBER: D13601	29d. DATE SIGNED (Month, Day, Year): 8/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR V FELIPA 925 BISHOP WALSH RD CUMBERLAND, MD 21502		
31. DATE FILED (Month, Day, Year): AUG 23 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23783

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EMILY CHAPLIN FREY				2. DATE OF DEATH (Month, Day, Year): 08/16/1989	3. TIME OF DEATH: 8:10P M
4. SOCIAL SECURITY NUMBER: 213740533	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/27/1900	8. BIRTHPLACE (State or Foreign Country): MARTINSBURG, W.VA.
8a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND. MD.		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CUMBERLAND, MARYLAND	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 404 NORTH CENTRE ST.		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOME	
17. FATHER'S NAME (First, Middle, Last): WILLIAM E. YARNALL		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA MURRAY CONNELL	
19a. INFORMANT'S NAME (Type/Print): WILFORD F. BLAUGH		19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 127 PARK AVE. LAVALE, MD. 21502	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ROSEDALE FUNERAL CHAPEL	20c. LOCATION — City or Town, State: MARTINSBURG, W.VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Scarpelli Jr.		22. NAME AND ADDRESS OF FACILITY: SCARPELLI FUNERAL HOME, CUMB., MARYLAND 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cerebral Vascular Accident	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Vascular Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary Wagoner MD	29c. LICENSE NUMBER: D22181	29d. DATE SIGNED (Month, Day, Year): ▶ 8-17-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GARY WAGONER 925 BISHOP WALSH CUMBERLAND MD 21502

31. DATE FILED (Month, Day, Year): AUG 18 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23784
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
HAZEL	O	JEFFRIES	August 14, 1989	10:35 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-20-1923	1 ☐ M 2 ☒ F	66 YRS.			Feb. 2, 1923	West Virginia

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital & Medical Center	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Allegany	Cumberland	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
205 Maple Street	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
8		Cook	Restaurant

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ernest N. Davis	"Essie" Thestle Wilson

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alan Jeffries	416 Fayette Street, Cumberland, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Etam Cemetery	Rowlesburg, WV

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Wendy D. Upchurch	George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COPD	40 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): continued cig abuse causing coronary artery disease	4 yrs
	c. DUE TO (OR AS A CONSEQUENCE OF): decreased left ventricular function	20 yrs
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Cerebral ~~stroke~~ aggravation damage 2° to PM.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	8/14/89 N/A	N/A M	1 ☐ YES 2 ☐ NO N/A	N/A

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
N/A	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
V. Poonai	D36766	▶ 8/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. V. Poonai, 719 Williams Street, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 17 1989	Julia Davidson-Randall

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DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23785 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDNA REGINA KEENE				2. DATE OF DEATH (Month, Day, Year): 8-18-89	3. TIME OF DEATH: 10 40P M
4. SOCIAL SECURITY NUMBER: 262888868	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-6-03	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Mt. Savage			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 1, Box 12		10f. ZIP CODE: 21545		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home			
17. FATHER'S NAME (First, Middle, Last): William Albert Murphy	18. MOTHER'S NAME (First, Middle, Maiden Surname): Henrietta Crowe				
19a. INFORMANT'S NAME (Type/Print): Donald E. Keene	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 493 - Frostburg, MD 21532				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Johnson Cemetery	20c. LOCATION — City or Town, State: Finzel, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wendy D. Yochusch	22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hemorrhagic Cerebrovascular Accident	6 hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
T E Clagett MD	MD 35135	▶ 8/20/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR G BREZA 912 SETON DR CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 21 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23786
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FLORENCE MAE MARTZ			2. DATE OF DEATH (Month, Day, Year): August 12, 1989	3. TIME OF DEATH: 6:45 P M
4. SOCIAL SECURITY NUMBER: 214-74-4991	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 1, 1898	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: LaVale 21502		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1250 Vocke Road		10f. ZIP CODE: 21502		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Charles Gantt		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Mae Durfey		
19a. INFORMANT'S NAME (Type/Print): Edward E. Martz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 Glenview Terrace, LaVale, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park		20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wendy D. Upchurch		22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home 202 Greene St., Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular tachycardia / fibrillation

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Ischemic cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 9 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Sagin MD — 29c. LICENSE NUMBER: D35481 — 29d. DATE SIGNED (Month, Day, Year): ▶ 8/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Mark Sagin Memorial Hospital, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): AUG 17 1989 — 32. REGISTRAR'S SIGNATURE: Trisha Davidson-Randall

DHMH-18 Rev 1/89

89 23787

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 of 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID ELLIS MCDOWELL			2. DATE OF DEATH: MONTH 08 DAY 25 YEAR 89	3. TIME OF DEATH: 15:59 M
4. SOCIAL SECURITY NUMBER: 214-10-5127	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01/23/07	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): SACRE D HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND MD		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Columbia Street 107		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Civil Engineer	16b. KIND OF BUSINESS/INDUSTRY: Engineering
17. FATHER'S NAME (First, Middle, Last): Andrew Stover McDowell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Iraminta Viola Myers	
19a. INFORMANT'S NAME (Type/Print): Richard McDowell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 119 John Street Hagerstown, Maryland 21740	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery	20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gerald N. Minnich		22. NAME AND ADDRESS OF FACILITY: Gerald N. Minnich Funeral Home	305 N. Potomac Street Hagerstown, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	1 hour
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ARTERIO-SCLEROTIC-HEART-DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Giovanni Mastrangelo Deouty M.E.		29c. LICENSE NUMBER: MD [illegible]D07098	29d. DATE SIGNED (Month, Day, Year): ▶ 8-25-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Giovanni Mastrangelo, M.D., Sacred heart Hosp. Lab, 900 Seton Dr. Cumberland,Md. 2150			
31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23788
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELEANOR MARIA MILLER			2. DATE OF DEATH (Month, Day, Year): 08-13-1989	3. TIME OF DEATH: 12:30 AM M
4. SOCIAL SECURITY NUMBER: 217301289	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08-26-1906	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: ALLEGANY COUNTY	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 824 Windsor Road		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): registered nurse	16b. KIND OF BUSINESS/INDUSTRY: hospital		
17. FATHER'S NAME (First, Middle, Last): Walter V. Dutton		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen C. Fainter		
19a. INFORMANT'S NAME (Type/Print): Mrs. Elizabeth A. Sell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 824 Windsor Road, Cumberland, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SS Peter Paul Cemetery	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	End stage Cardiomyopathy	years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Coronary artery disease	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cancer of colon

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D 33860	▶ 8/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. SUNIL GUPTA, 69 GREENE STREET, CUMBERLAND, MARYLAND 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 17 1989	Julia Davidson-Randall

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23789

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN BERNARD MILLER		2. DATE OF DEATH (Month, Day, Year): 8-14-89	3. TIME OF DEATH: 8:20P M
4. SOCIAL SECURITY NUMBER: 214059987	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 10, 1915 — 8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: ALLEGANY	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Frostburg	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 102 Walnut Street	10f. ZIP CODE: 21532	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Miner	16b. KIND OF BUSINESS/INDUSTRY: Coal	
17. FATHER'S NAME (First, Middle, Last): Wesley Miller	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sallie Hansel		
19a. INFORMANT'S NAME (Type/Print): James Miller	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 95 Wright St. Frostburg Maryland 21532		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park	20c. LOCATION — City or Town, State: Frostburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John R. Durst	22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home 57 Frost Avenue Frostburg Md. 21532		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. acute Respiratory Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. cardiopulmonary arrest	
DUE TO (OR AS A CONSEQUENCE OF):		
	c. acute Left Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
	d. Rapid atrial Fibrillation	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute bacterial Pneumonia, Sepsis
Chronic Obstructive Pulmonary Disease
acute renal failure, H/O Bladder Cancer

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Orlino D.O.	29c. LICENSE NUMBER: D34846	29d. DATE SIGNED (Month, Day, Year) ▶ 8/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR R ORLINO 900 SETON DR CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year): AUG 17 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

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DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23790
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use of the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alan J. Schneider			2. DATE OF DEATH (Month, Day, Year): 8-11-89	3. TIME OF DEATH: 2:30AM M
4. SOCIAL SECURITY NUMBER: 166-42-1352	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 7, 1950	8. BIRTHPLACE (State or Foreign Country): Upland, Pa.
9a. FACILITY NAME (If not institution, give street and number): Route 40, Polish Mountain		9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH: Allegany County	

RESIDENCE OF DECEDENT

10a. STATE: Pa.	10b. COUNTY: Delaware	10c. CITY, TOWN OR LOCATION: Exton	10d. INSIDE CITY LIMITS? [X] 1 YES [ ] 2 NO
10e. STREET AND NUMBER: 210 N. Severyn Drive		10f. ZIP CODE: 19341	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2yrs	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): self-employed	16b. KIND OF BUSINESS/INDUSTRY: Arrow Services
17. FATHER'S NAME (First, Middle, Last): John A. Schneider		18. MOTHER'S NAME (First, Middle, Maiden Surname): Patricia Adams	
19a. INFORMANT'S NAME (Type/Print): Patricia A. Schneider		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4002 Chichester Ave., Boothwyn, Pa.19061	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lawn Croft Cem.	20c. LOCATION — City or Town, State: Lower Chichester, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward McLaughlin		22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home	259 E. Main Street, Elkton, Md. 21921

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX 1 YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX 1 YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX 1 YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence XXX 6 [ ] Other (Specify) Scene		
27. MANNER OF DEATH: 1 [ ] Natural XXX 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-11-89	28b. TIME OF INJURY: 2:20AM	28c. INJURY AT WORK? 1 [ ] YES XXX NO
	28d. DESCRIBE HOW INJURY OCCURED: Driver of pick-up/tractor trailer collision		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 40/Polish Mountain, Allegany County, Maryland	

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr. M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-11-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201		VC
31. DATE FILED (Month, Day, Year): AUG 14 '89	32. REGISTRAR'S SIGNATURE: [illegible]	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23791

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM ANTHONY SHUCK			2. DATE OF DEATH (Month, Day, Year): 08/15, 1989	3. TIME OF DEATH: 12:15 AM M
4. SOCIAL SECURITY NUMBER: 219038714	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5/26/20	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: FROSTBURG	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 111 ARMSTRONG STREET		10f. ZIP CODE: 21532	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RESOURCE CONSULTANT	16b. KIND OF BUSINESS/INDUSTRY: JUVENILE SERVICES
17. FATHER'S NAME (First, Middle, Last): ROBERT SHUCK		18. MOTHER'S NAME (First, Middle, Maiden Surname): NELLIE KLOSTERMAN	
19a. INFORMANT'S NAME (Type/Print): MADESTA SHUCK		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 ARMSTRONG ST., FROSTBURG, MD 21532	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FROSTBURG MEMORIAL PARK	20c. LOCATION — City or Town, State: FROSTBURG, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marlon M. Sowers		22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME, 60 W. MAIN ST. FROSTBURG, MD 21532	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	metastatic cancer	
DUE TO (OR AS A CONSEQUENCE OF): b.	Hypercalcemia 2° to A	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe COPD + ASTHMA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Orlino MD	29c. LICENSE NUMBER: D 34846	29d. DATE SIGNED (Month, Day, Year): ▶ 8/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT ORLINO, M.D. 900 SETON DRIVE, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year): AUG 18 1989	32. REGISTRAR'S SIGNATURE: Trisha Davidson-Randall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 23792

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
NORMAN	THOMAS	SMITH SR.	August 20, 1989	11:00 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-07-1102	1 [X] M 2 [ ] F	73 YRS.			11-09-1915	MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Allegany	Cumberland	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
113 Grand Avenue	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO — WW II	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		former employee	Plaining Mill/Bd of Education

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Harry L. Smith	Nora Wishmyer

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marian A. Smith	113 Grand Avenue, Cumberland, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Restlawn Memorial Gardens	LaVale, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James Scarpelli	Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ventricular fibrillation	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Septic Shock.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. PNEUMONIA.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Coronary Artery Disease, COPD

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Ranjithan	D19318	▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. N. Ranjithan Memorial Hospital Medical Building Cumberland, Md. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 22 1989	Julia E. Hazen

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23793
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MELVIN EDWARD TWIGG			2. DATE OF DEATH (Month, Day, Year): August 20, 1989	3. TIME OF DEATH: 1:30 P.M
4. SOCIAL SECURITY NUMBER: 217-14-4081	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-11-1919	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: LaVale	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 802 Valley View Drive		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired lineman	16b. KIND OF BUSINESS/INDUSTRY: Potomac Edison Electric		
17. FATHER'S NAME (First, Middle, Last): H. Clay Twigg		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rhoda Bucy		
19a. INFORMANT'S NAME (Type/Print): Phyllis E. Twigg		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Valley View Drive, LaVale, MD 21502		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Hillcrest Burial Park	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Advanced Ca. Bladder c mets to Liver
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Qamar Zaman MD	D23371	▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Qamar Zaman, Memorial Hospital Medical Building, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 22 1989	[illegible]

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12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 23794
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DENVER HARRISON WHITACRE		2. DATE OF DEATH (Month, Day, Year): August 21, 1989	3. TIME OF DEATH: 10:55 A M
4. SOCIAL SECURITY NUMBER: 212-12-8625	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 03-16-1909
8. BIRTHPLACE (State or Foreign Country): WV			
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT			
10a. STATE: WV	10b. COUNTY: Mineral	10c. CITY, TOWN OR LOCATION: Wiley Ford	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: P.O. Box 308	10f. ZIP CODE: 26767	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed mechanic	16b. KIND OF BUSINESS/INDUSTRY: Garage	
17. FATHER'S NAME (First, Middle, Last): Harrison Whitacre	18. MOTHER'S NAME (First, Middle, Maiden Surname): (nmn)		
19a. INFORMANT'S NAME (Type/Print): Rosa C. Whitacre	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 308, Wiley Ford, WV 26767		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens	20c. LOCATION — City or Town, State: LaVale, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio-pulomnary arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary artery heart disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Snow MD Dpty. MEd. Ex.
29c. LICENSE NUMBER: D09157
29d. DATE SIGNED (Month, Day, Year): ▶ August 21, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Snow MD Dpty. MEd. Ex. 124 West Third Street, Cumberland, MD. 21502

31. DATE FILED (Month, Day, Year): AUG 22 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Kendall

DHMN-18 Rev 1/89